HAMPTON ROADS ORAL AND MAXILLOFACIAL SURGERY
PATIENT REGISTRATION

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt ____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____ Sex: M F

Social Security # _____ Date of Birth _____ Age _____ Marital Status: S M D W

Employer _____ Occupation _____ If student, school _____

My dentist is _____ I was referred by _____

Emergency contact _____ Relationship _____ Phone _____ (H) (W) (C)

Responsible Party (if different from patient) – must be present

Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt ____ City _____ State _____ Zip Code _____

Social Security # _____ Date of Birth _____ Relationship to Patient: Spouse Parent Other

Employer _____ Occupation _____ Phone _____ (H) (W) (C)

Medical Insurance Information

Insurance Company _____ Phone _____

Claim Address _____

Policy ID # _____ Group # _____ Plan # _____

Policy Holder's: Name _____ SS# _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

DOB _____ Relationship to Patient: Self ___ Spouse ___ Child ___ Other ___

Employer _____

Dental Insurance Information

Insurance Company _____ Phone _____

Claim Address _____

Policy ID # _____ Group # _____ Plan # _____

Policy Holder's: Name _____ SS# _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

DOB _____ Relationship to Patient: Self ___ Spouse ___ Child ___ Other ___

Employer _____

PLEASE LET US KNOW IF YOU HAVE ADDITIONAL INSURANCE COVERAGE

An estimate of the charge for any procedure or surgery you may require will be given to you. Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I understand I am financially responsible for payment of all services at the time they are rendered, unless other payment arrangements have been established. I hereby authorize treatment to patient by the above physicians and/or any affiliated medical staff member(s). I further authorized release of any and all medical and/or charge information as is necessary for third party reimbursement from my insurance carrier. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all charges incurred as well as attorney's fees any other costs of collections should such action become necessary.

By signing below, I give my consent to be contacted by regular mail, email, text messages or by phone on my cell phone regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages if account is not paid. This consent applies to all healthcare providers covered under this agreement.

_____ _____ _____

Signature of Patient / Responsible Party | Relationship of Patient | Date

Hampton Roads Oral & Maxillofacial Surgery Health History Form

Patient's Name _____ *Nickname* _____ *Date of Birth* ____/____/_____

Gender: Male / Female *Height* _____ *Weight* _____

Physician _____ *Dentist* _____ *Referred by* _____

Pharmacy and Location (for e-Prescriptions) _____

Reason for Office Visit _____

_____

Describe your current health: *Excellent* *Good* *Fair* *Poor*

Have you been hospitalized for a serious illness/major surgery? *Yes* *No*

If yes, for what? _____

_____

Patient Medical History *(Mark any of the following conditions that you have or have ever had)*

□*Congenital Heart Disease*
□*Heart Attack*
□*Chest Pain/Angina*
□*Heart Failure*
□*Irregular Heartbeat*
□*Heart Surgery/Stents*
□*Pacemaker/Defibrillator*
□*Heart Murmur*
□*Heart Valve Replacement*
□*Infective Endocarditis*
□*Hypertension*
□*Stroke/Mini-Stroke*
□*Venous Thrombosis*
□*Pulmonary Embolus*
□*Asthma*
□*Chronic Bronchitis*
□*Emphysema*
□*Tuberculosis*
□*Shortness of Breath*
□*Obstructive Sleep Apnea*

□*Bleeding Disorder*
□*Anemia*
□*Blood Transfusion*
□*Liver Disease/Hepatitis*
□*Kidney Disease*
□*Dialysis*
□*Thyroid Disease*
□*Diabetes*
□*Stomach Ulcers*
□*Gastric Reflux*
□*Ulcerative Colitis*
□*Crohns' Disease*
□ *Seizures/Epilepsy*
□*Fainting/Dizziness*
□*Neuromuscular Disorder*
□*Autoimmune Disorder*
□*Organ Transplant*
□*Depressed Immune System*
□*Arthritis*
□*Artificial Joint (knee, hip)*

□*Cancer/Type* _____
□*Chemotherapy*
□*Radiation Therapy to Head/Neck*
□*Sinus/Nasal Problems*
□*HIV/AIDS*
□*Herpes/Cold Sores*
□*Sexually Transmitted Disease*
□*Nervous Disorder/Anxiety*
□ *Mental Health Disorder*
□*Intellectual Disability*
□*Dementia/Alzheimer's*
□*Autism Spectrum Disorder*
□*ADD/ADHD*
□*Substance Abuse/Addiction*
□*Osteoporosis/Osteopenia*
□*TMJ disorder (pain, noise)*
_____
_____
_____
_____

Are you taking any blood thinners (Coumadin, Xarelto, Eliquis, Plavix, Aspirin)? *Yes* *No*

Are you or have you ever taken any bisphosponates or anti-resorptive medications for osteoporosis, multiple myeloma or cancer (Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos, Reclast, Prolia, Xgeva)? *Yes* *No*

Have you ever been told you should premedicate with antibiotics prior to a dental appointment? (Example: prosthetic joint, artificial heart valve) *Yes* *No*

(OVER)

Female Patients

Are you pregnant or trying to become pregnant? *Yes* *No* *Due date:* _____

Are you currently nursing? *Yes* *No*

Medications *(Please list all medications that you are taking or provide office with an up to date printed list):*

_____

_____

_____

_____

Allergies/Adverse Reaction *(Mark any that apply and describe reaction)*

□*No Known Drug Allergies*

□*Latex* _____

□*Penicillin/Amoxicillin* _____

□*Other Antibiotics* _____

□*Local Anesthestics* _____

□*General Anesthetic/Sedatives* _____

□*Aspirin* _____

□*Motrin/Ibuprofen/Aleve* _____

□*Codeine* _____

□*Other Narcotic Pain Medication* _____

□*Iodine* _____

Other: _____

Social History

Do you or have you smoked? *Y* *N* *Packs per day* _____ *Years* _____ *Date when Quit* _____

Do you or have you chewed tobacco? *Y* *N* *Use per day* _____ *Years* _____ *Date when Quit* _____

Do you frequently drink alcohol? *Y* *N* *Drinks/day* _____ *Years* _____ *Date when Quit* _____

Recreational Drugs? *Marijuana* *Cocaine* *Heroin* *Narcotics* *Meth* *How often?* _____

Have you ever been under professional care or hospitalized for alcoholism/substance abuse? *Yes* *No*

Surgical/Anesthesia History:

Have you had problems with any previous surgeries? *Yes* *No*

□*Nausea/Vomiting*

□*Prolonged Bleeding*

□*Blood Transfusion Required*

□*Other* _____

Do you or any immediate family members have malignant hyperthermia? *Yes* *No*

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

Patient, parent/guardian signature _____ ***Date*** _____

Printed name of patient, parent, guardian/relationship _____