SOUTH SHORE ORAL SURGERY ASSOCIATES

DR. STEVEN J. VERVENIOTIS | DR. RICHARD M. MIRRA | DR. MATTHEW GREEN

# Patient Registration

## PATIENT INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mr. Mrs. Ms. | First Name | | M.I. | | Last Name | | |
| Gender | ❑ Male ❑ Female | Birth Date | | Age | | Social Security # | |
| Address | | City | | State | | ZIP Code | |
| Email | | Home Phone | | Cell Phone | | | |
| Marital Status | ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single | | | | | | |
| Employment Status | ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Employed | | | | | | |
| Employer | | Business Telephone | | | | | |
| Student Status | ❑ Full Time ❑ Part Time ❑ Not a Student | | | | | | |
| Pharmacy Name | | Address | | | | Phone | |
| Referral By | | Medical Doctor | | | | | |
| Dentist | | | | | | | |
| Referral Address | | City | | State | | ZIP Code | |

**Who will be responsible for your account? (if self is selected, please skip to next section)**

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

| | | | | | |
|---|---|---|---|---|---|
| First Name | | Last Name | | Social Security # | |
| Birth Date | | Home Phone | | Cell Phone | |
| Email | | | | | |
| Address | | City | State | | ZIP Code |

## INSURANCE INFORMATION

### PRIMARY DENTAL INSURANCE COMPANY

| | | | | | |
|---|---|---|---|---|---|
| Primary Policy Holder | First Last | | | Relation | |
| Birth Date | | Gender | ❑ Male ❑ Female | S.S. # | | Telephone | |
| Address | | City | | State | | ZIP Code | |
| Primary Policy Holder Employer | | | | Employer ID # | |
| Address | | City | | State | | ZIP Code | |
| Is this an Employer Health Insurance Plan? | | | | ❑ Yes | ❑ No |
| Insurance Co. Name | | | | Telephone | |
| Address | | City | | State | | ZIP Code | |
| Group # | | | | Policy ID # | |
| Purchased through Federal Website? | ❑ Yes | ❑ No | By: | ❑ You | ❑ Your Employer |

## HEALTH HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Are you in good health? | ❑ Yes | ❑ No | Height | | Weight | |
| Have there been any changes to your general health in the past year? | | | | ❑ Yes | ❑ No |
| Are you under the care of a physician? | ❑ Yes | ❑ No | If yes, for what condition? | | |
| Have you had any illness, operation, or have been hospitalized in the past five years? | | | | ❑ Yes | ❑ No |
| If yes, please describe | | | | | |
| Have you had an artificial joint replacement (knee, hip, shoulder, etc)? | | | | ❑ Yes | ❑ No |
| Have you had or do you have arteriosclerosis or any other heart condition? | | | | ❑ Yes | ❑ No |
| ❑ Chest pain upon exertion | ❑ Shortness of breath after mild exercise | ❑ Do your ankles swell | | | |
| Have you had or do you have any disease, drug or transplant operation that has depressed your immune system? | | | | ❑ Yes | ❑ No |
| Have you ever had treatment for a tumor, cancer, or growth? | | | | ❑ Yes | ❑ No |
| Have you ever had radiation therapy to head, neck, or jaws? | | | | ❑ Yes | ❑ No |

| | | | | | |
|---|---|---|---|---|---|
| Do you smoke or chew tobacco? | ❑ Yes | ❑ No | How much? | | |
| Do you use alcohol? | ❑ Yes | ❑ No | Per week? | | Per month? |
| Have you had any serious trouble with previous dental treatment? | | | | ❑ Yes | ❑ No |
| If yes, please describe | | | | | |

**Have you had or do you currently have the following:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Damaged heart valves? | | | Diabetes or hypoglycemia? | | |
| Artificial valves? | | | Hepatitis A? | | |
| Heart murmur? | | | Hepatitis B? | | |
| Rheumatic heart disease? | | | Hepatitis C? | | |
| Heart attack? | | | Jaundice/ Liver disease? | | |
| Angina? | | | Sleep apnea? | | |
| High blood pressure? | | | Migraines? | | |
| Stroke? | | | AIDS/HIV? | | |
| Allergies (other than medications)? | | | Herpes? | | |
| Asthma/ Hay fever? | | | What kind? | | |
| Fainting spells/ Seizures? | | | Abnormal bleeding or disorder? | | |
| Thyroid problems? | | | Anemia? | | |
| Arthritis or painful, swollen joints? | | | Blood transfusion? | | |
| Osteoporosis? | | | History of chemical dependency? | | |
| Stomach ulcers or hyperacidity? | | | History of alcohol dependency? | | |
| Kidney trouble? | | | Emotional disorder (depression, etc)? | | |
| Tuberculosis? | | | Contact lenses? | | |
| Epilepsy/ Neurological disorder? | | | Removable dental appliance? | | |
| Difficulty opening & closing your mouth? | | | | | |
| Do you have any condition or disease you think the doctor should know about? | | | | ❑ Yes | ❑ No |
| If yes, please describe | | | | | |

## MEDICATIONS

**Are you taking any of the following:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| *Are you taking blood thinners (including Aspirin)? | | | | | |
| Are you taking or have you ever taken medication for osteoporosis or been treated with chemotherapy? | | | | | |
| Fosamax | | | Aredia | | |
| Actonel | | | Prolia | | |
| Boniva | | | Reclast | | |
| Zometa | | | Other | | |
| Are you taking any medications including diet pills, non-prescription, vitamins, homeopathic or natural remedies? | | | | | |

**If yes, please list:*

*If you take the blood thinners Coumadin or Warfarin, we need your INR blood work 24-48 hours prior to surgery.*

**If yes, please list:**

## ALLERGIES/REACTIONS

**Are you allergic to, or had a reaction to any of the following:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Local anesthetic? | | | Iodine? | | |
| Penicillin? | | | Codeine? | | |
| Other antibiotics? | | | Other narcotics? | | |
| If yes, please list: | | | If yes, please list: | | |
| Barbiturates or sleep pills? | | | Latex or rubber products? | | |

| | | | | |
|---|---|---|---|---|
| **Aspirin, Ibuprofen, Acetaminophen?** | | | **Other** | |

## FOR WOMEN ONLY

| | | | | |
|---|---|---|---|---|
| **Are you pregnant or trying to become pregnant?** | | | | ❑ Yes ❑ No |
| **Are you nursing?** | ❑ Yes | ❑ No | **Are you taking birth control pills?** | ❑ Yes ❑ No |

**WARNING:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

## FORM COMPLETION

**I have read and understand the above. I understand the importance of a truthful and complete Health History to assist in providing the best care possible. I hereby acknowledge that all information above is correct.**

| | | | |
|---|---|---|---|
| **Patient Signature** (Parent or Guardian if minor)**:** | | **Date:** | |

## FEES AND PAYMENTS

**We make every effort to keep down the cost of your oral surgical care. You can help by paying on completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance, we will be glad to fill out the proper forms, but please complete the identifying information at the top of the form.**

**Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other 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. Any account over 90 days will be charged a 1-1/2% finance charge monthly with an annual rate of 18%, in addition to any collection agency fees and/or attorney fees and court costs incurred in the collection of outstanding balances.**

**This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist's name of the insurance benefits otherwise payable to me.**

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I hereby acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices. I give my permission to discuss this account to the following:**

**1.** _____

**2.** _____

**3.** _____

| | | | |
|---|---|---|---|
| **Patient Signature** (Parent or Guardian if minor)**:** | | **Date** | |

## IF PATIENT IS A MINOR

| | | | |
|---|---|---|---|
| **Form signed by** | | **Relationship to Patient** | |