SOUTH SHORE ORAL SURGERY ASSOCIATES

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

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 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**	