NORTH JERSEY
ORAL & MAXILLOFACIAL SURGERY

315 Cedar Lane, Teaneck NJ 07666
Phone: (201) 692-7737 | Fax: (201) 287-9716
WWW.NORTHJERSEYORALSURGERY.COM

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date ____________

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name ____________ M.I. ____ Last Name ____________

Sex: ☐Male ☐Female Birthdate ____________ Age ____ Soc. Sec. # ____________ Email ____________

Street ____________ City ____________ State ______ Zip ______

Home Tel. (_____) ____________ Cell (_____) ____________ Have you ever been a patient of our practice? ☐Yes ☐No

Referred By ____________ (FIRST NAME) ____________ (LAST NAME) Has a family member ever been a patient of our practice? ☐Yes ☐No

Dentist ____________ (FIRST NAME) ____________ (LAST NAME) Orthodontist ____________ (FIRST NAME) ____________ (LAST NAME) Medical Dr. ____________ (FIRST NAME) ____________ (LAST NAME)

Driver Lic. # ____________ Nearest relative not living with you ____________ (FIRST NAME) ____________ (LAST NAME) Tel. (_____) ____________

Employer ____________ Bus. Tel. (_____) ____________ Personal Payment Type: ☐Cash ☐Check ☐Credit Card

In case of emergency, please contact ____________ Tel. (_____) ____________ Relation ____________

PERSON RESPONSIBLE FOR ACCOUNT

☐Self (If self, skip this section) ☐Spouse ☐Father ☐Mother ☐Other ____________

Name ____________ (FIRST NAME) ____________ (LAST NAME) S.S. # ____________ Birthdate ____________ Age ______

Tel. (_____) ____________ Cell (_____) ____________ Email ____________

Street ____________ Apt. ______ City ____________ State ______ Zip ______

Driver's Lic. # ____________ Employer ____________ Bus. Tel. (_____) ____________

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

Name ____________ (FIRST NAME) ____________ (LAST NAME) Relation ____________ S.S. # ____________ Birthdate ____________

Street ____________ Apt. ______ City ____________ State ______ Zip ______

Tel. (_____) ____________ Employer ____________ Bus. Tel. (_____) ____________

INSURANCE INFORMATION

Student: . . . . . . ☐Full Time ☐Part Time ☐Not. . . . . School Name and Address ____________ (SCHOOL NAME) ____________ (ADDRESS)

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Single ☐Legally Separated ____________ (CITY) ______ (STATE) ______ (ZIP)

Employed: . . . . ☐Full Time ☐Part Time ☐Retired ☐Not. . . . . Do you belong to a PPO or HMO? ☐Yes ☐No

PRIMARY DENTAL INSURANCE

Employer ____________

Bus. Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Bus. Tel. (_____) ____________ Plan ____________

Ins. Co. Name ____________ I.D. # ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Tel. (_____) ____________ Group Name ____________

Group # ____________ Insured Party ____________ (FIRST NAME) ____________ (LAST NAME)

Relation ____________ Birthdate ____________ Sex: ☐M ☐F

S.S. # ____________ Tel. (_____) ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

PRIMARY MEDICAL INSURANCE

Employer ____________

Bus. Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Bus. Tel. (_____) ____________ Plan ____________

Ins. Co. Name ____________ I.D. # ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Tel. (_____) ____________ Group Name ____________

Group # ____________ Insured Party ____________ (FIRST NAME) ____________ (LAST NAME)

Relation ____________ Birthdate ____________ Sex: ☐M ☐F

S.S. # ____________ Tel. (_____) ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

SECONDARY DENTAL INSURANCE

Employer ____________

Bus. Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Bus. Tel. (_____) ____________ Plan ____________

Ins. Co. Name ____________ I.D. # ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Tel. (_____) ____________ Group Name ____________

Group # ____________ Insured Party ____________ (FIRST NAME) ____________ (LAST NAME)

Relation ____________ Birthdate ____________ Sex: ☐M ☐F

S.S. # ____________ Tel. (_____) ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

SECONDARY MEDICAL INSURANCE

Employer ____________

Bus. Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Bus. Tel. (_____) ____________ Plan ____________

Ins. Co. Name ____________ I.D. # ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

Tel. (_____) ____________ Group Name ____________

Group # ____________ Insured Party ____________ (FIRST NAME) ____________ (LAST NAME)

Relation ____________ Birthdate ____________ Sex: ☐M ☐F

S.S. # ____________ Tel. (_____) ____________

Address ____________ (ADDRESS) ______ (CITY) ______ (STATE) ______ (ZIP)

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HEALTH HISTORY

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit: ______________________________

		Yes	No
1.	Height__________ Weight__________ Are you in good health?	☐	☐
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? *Date of last visit* __________ *If so, for what are you being treated?*__________	☐	☐
4.	Have you had any illness, operation, or been hospitalized in the past five years? *If so, describe*__________	☐	☐
5.	Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? *If so, describe where*__________	☐	☐
6.	Do you have a prosthetic joint/implant? *If so, describe where* __________	☐	☐
7.	Have you had a heart valve replacement or vascular graft?	☐	☐

Have you had or do you currently have any of the following?	YES	NO	NOTES
8. Rheumatic fever			
9. Damaged heart valves/ mitral valve prolapse			
10. Heart murmur			
11. High blood pressure			
12. Low blood pressure			
13. Chest pain/angina			
14. Heart attack(s)			
15. Irregular heart beat			
16. Cardiac pacemaker			
17. Heart surgery			
18. Bronchitis, chronic cough			
19. Asthma			
20. Hay fever/sinus problems			
21. Snoring/sleep apnea			
22. Difficult breathing/other lung trouble			
23. Tuberculosis			
24. Emphysema			
25. Do you smoke? If so, number of packs a day ______			
26. Do you use chewing tobacco?			
27. Blood transfusion			
28. Blood disorder such as anemia			
29. Bruise easily			
30. Bleeding tendency/abnormal bleeding			
31. Hepatitis, jaundice, or liver disease			
32. Infectious mononucleosis			
33. Gallbladder trouble			
34. Fainting spells			
35. Convulsions/epilepsy			

Have you had or do you currently have any of the following?	YES	NO	NOTES
36. Stroke			
37. Thyroid trouble			
38. Diabetes			
39. Low blood sugar			
40. Kidney trouble			
41. Are you on dialysis?			
42. Swollen ankles/arthritis/joint disease			
43. Stomach ulcers			
44. Contagious diseases			
45. Sexually transmitted diseases			
46. Are you immunosuppressed? Possibly from transplant surgery, etc.			
47. Problems with immune system, possibly from medication/surgery, etc.			
48. Delay in healing			
49. A tumor or growth			
50. Radiation therapy/chemotherapy			
51. Chronic fatigue/night sweats			
52. Are you on a diet?			
53. A history of alcohol abuse			
54. A history of drug abuse			
55. Contact lenses			
56. Eye disease/glaucoma			
57. Mental health problems/anxiety/ depression			
58. A removable dental appliance			
59. Pain or clicking of jaws when eating			
60. Malignant hyperthermia			
61. **IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
62. Who is driving you home?			

WOMEN ONLY: (QUESTIONS 64–67)

		Yes	No
63.	Is there a possibility of pregnancy?	☐	☐
64.	Expected delivery date?__________		
65.	Are you nursing?	☐	☐
66.	Are you taking birth control pills?	☐	☐

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

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HEALTH HISTORY (CONT.)

MEDICATION Are you now taking any of the following?	YES	NO	NOTES
67. Any kind of medication, drug, pills			
68. Blood thinners (Coumadin®, Plavix®, aspirin, vitamin E, ginkgo biloba, Aggrenox®, Pradaxa®, fish oil)			
69. Have you ever taken diet pills?			
70. Any natural product, herbal supplement, or homeopathic remedy			
71. Any bone density medications or bisphosphonates such as Fosamax®, Actonel®, IV-Zometa®, Boniva®, or Aredia® in the past 12 years?			
72. Tranquilizers, antidepressants, sleeping pills, and/or narcotics on a regular basis If so, please list:			

73. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Is there any condition concerning your health that the doctor should be told about? ☐ Yes ☐ No If yes, describe: ____________________

Do you wish to speak to the doctor privately about anything? ☐ Yes ☐ No

Is there a family history of any of the following?	Yes	No
89. Cancer	☐	☐
90. Diabetes	☐	☐
91. Heart disease	☐	☐
92. Anesthesia problems	☐	☐

ALLERGIES Are you allergic to or have you had a reaction to any of the following?	YES	NO	NOTES
74. Local anesthetic (numbing meds)			
75. Penicillin			
76. Other antibiotics			
77. Sulfa drugs			
78. Sodium pentothal/Valium®/ other tranquilizers			
79. Aspirin			
80. Amoxicillin			
81. Codeine or other narcotics			
82. Other medications			
83. Latex			
84. Soy			
85. Eggs/yolk			
86. Sulfites			
87. Do you have any known allergies?			

88. Please list any allergies other than drug allergies:

Is this visit related to an accident? ☐ Yes ☐ No

If yes, what type of accident? ☐ Automobile ☐ Work-Related ☐ Other

Date of injury ____________________

Insurance company handling the claim ____________________

Claim number ____________________

Name of attorney/adjustor ____________________

Phone # (______) ____________________

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X ____________________ **X** __________ **X** ____________________ **X** __________
Signature of Patient *(Parent or Guardian if Minor)* **Date** **Reviewed By** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon 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 and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this 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 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. You will be responsible for all collection costs, attorney's fees, and court costs.

X ____________________ **X** __________
Signature of Patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ____________________ **X** __________
Signature of Patient *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all X-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment.

X ____________________ **X** __________ **X** __________ **X** __________
Signature of Patient *(Parent or Guardian if Minor)* **Witness** **Doctor** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ____________________ **X** __________
Signature of Patient *(Parent or Guardian if Minor)* **Date**