

PATIENT REGISTRATION FORM

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I. Patient Information

Marital Status Single Married Family Dentist: _____ Family Physician: _____

Title _____ Suffix _____ Sex: M F Date of Birth _____ Age: _____

Last _____ First _____ MI _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Social Security # _____ Driver's License: _____

II. Employment Information

Patient's Employer _____ Occupation: _____

Employer Address _____

City/State/Zip _____ Phone _____

Responsible Party Name _____

Responsible Party Employer _____ Occupation: _____

Employer Address _____

City/State/Zip _____

Phone _____ SS # _____

III. Insurance Information

PRIMARY: Insurance Type : Medical Dental

SECONDARY: Insurance Type : Medical Dental

Subscriber _____ Name of Carrier _____

Subscriber _____ Name of Carrier _____

Group # _____ DOB _____

Group # _____ DOB _____

Agreement _____ Subscriber's SS # _____

Agreement _____ Subscriber's SS # _____

Plan _____ Policy # _____

Plan _____ Policy # _____

HEALTH QUESTIONNAIRE FORM

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I. General Information

Name: _____ Date: _____

Reason for today's office visit: _____

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

Yes No Are you in good health? Height: _____ Weight: _____

Yes No Have there been any changes in your general health in the past year?

Yes No Are you under the care of a physician? Date of last visit: _____
If YES, for what are you being treated? _____

Yes No Have you had any illness, operation, or been hospitalized in the past five years?
If YES please list: _____

Have you had or do you currently have ...				Have you had or do you currently have ...			
	YES	NO	NOTES		YES	NO	NOTES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Anesthetic Problems (Family History)	<input type="checkbox"/>	<input type="checkbox"/>		History of Drug / Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>		Jaundice, Hepatitis, Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis, Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	
Chemotherapy or Radiation	<input type="checkbox"/>	<input type="checkbox"/>		Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>		Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	
Contagious Disease	<input type="checkbox"/>	<input type="checkbox"/>		Are you pregnant / nursing? (estimated due date)	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		Problems with Immune System	<input type="checkbox"/>	<input type="checkbox"/>	
Delay in Healing	<input type="checkbox"/>	<input type="checkbox"/>		Prosthetic Knee / Hip etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Removable Dental Appliance	<input type="checkbox"/>	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Smoker	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Sores in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>		Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>		Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever / Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		TMJ-Pain & Clicking of Jaws	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease (Family History)	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur/Artificial Valves	<input type="checkbox"/>	<input type="checkbox"/>		Tumor or Growth	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>					

HEALTH QUESTIONNAIRE FORM

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Name: _____ Date: _____

II. Allergy Information

	YES	NO	NOTES		YES	NO	NOTES
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>		Codeine or other Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>		Other Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Sodium Pentothal, Valium or other Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>		<i>(Please List)</i>			
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>		Allergies other than Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
				Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	
				Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

III. Medication Information

	YES	NO	NOTES		YES	NO	NOTES
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Anticoagulant (Blood Thinners)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

List all medications, drugs or pills:

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

Yes No Is there any condition concerning your health that the Doctor should be made aware of?
If YES please explain:

Yes No Is this visit related to an accident?

Type of Accident: Auto Work Related Other: _____
Date of Injury: _____ Insurance Company Handling Claim: _____
Name of Attorney / Adjuster: _____ Telephone #: _____

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 surgeon, or any other member of his staff, responsible for errors or omissions that I have made in the completion of this form.

Patient's (or Legal Guardian's) Signature

Date

CONSENT FOR USE & DISCLOSURE OF HEALTH INFO.

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Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____

Email: _____

Patient Number: _____

Social Security Number: _____

Section B: To the Patient - Please Read the Following Statements Carefully.

► **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

► **Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Paul T., Timothy J. and Paul Casey Fallon
Telephone: (315) 451-6988
Fax: (315) 453-0150
Address: 4820 West Taft Road, Liverpool, NY 13088

► **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

► **Fees & Payments:** Although we accept payments from your insurance company toward your account, you are responsible for your full account. I am aware that they accept Master Card and Visa. **WE ARE A NON PARTICIPATING PROVIDER FOR ANY INSURANCE COMPANY.** I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee based on my amount outstanding. 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.

SIGNATURE OF GUARANTOR: _____

Date: _____

► **Signature:** I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

► **Revocation of Consent:** I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Witness

Patient, Parent or Guardian

Date

Witness

Doctor

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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Patient's Name

Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

- _____ 1. Swelling and/or bruising and discomfort in the surgery area.
- _____ 2. Stretching of the corners of the mouth resulting in cracking or bruising.
- _____ 3. Possible infection requiring additional treatment.
- _____ 4. Dry socket - jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.
- _____ 5. Possible damage to adjacent teeth, especially those with large fillings or caps.
- _____ 6. Numbness, pain, or altered sensations in the teeth, gums, lip tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.
- _____ 7. Trismus - limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exists.
- _____ 8. Bleeding - significant bleeding is not common, but persistent oozing can be expected for several hours.
- _____ 9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.
- _____ 10. Incomplete removal of tooth fragments - to avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.
- _____ 11. Sinus involvement - the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.
- _____ 12. Jaw fracture - while quite rare, it is possible in difficult or deeply impacted teeth.

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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Teeth to be removed: _____

Alternative treatment: _____

ANESTHESIA:

LOCAL ANESTHESIA: (Novocaine, Lidocaine, etc.) is given to block pain pathways in a localized area.

LOCAL ANESTHESIA WITH NITROUS OXIDE: Nitrous Oxide (or Laughing Gas) helps to decrease uncomfortable sensations and offers some degree of relaxation.

LOCAL INTRAVENOUS SEDATION OR GENERAL ANESTHESIA: alters your awareness of the procedure by producing sedative/amnesic effects, or sleep.

Whichever technique you choose, the administration of any medication involves certain risks. These include:

1. Nausea and vomiting.
2. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require treatment.

In addition, there may be:

1. Pain, swelling, inflammation or infection of the area of the injection.
2. Injury to nerves or blood vessels in the area.
3. Disorientation, confusion, or prolonged drowsiness after surgery
4. Cardiovascular or respiratory responses which may lead to heart attack, stroke, or death.

Fortunately, these complications and side effects are not common. Well-monitored anesthesia is generally very safe, comfortable, and well-tolerated. If you have any questions, PLEASE ASK.

I have read and understand the above and give my consent for:

- Local Anesthesia
- Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Intravenous Sedation
- General Anesthesia

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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CONSENT

I have read and understand the above and give my consent to surgery. I further state that if I have IV Sedation or General Anesthesia, that I HAVE NOT HAD ANY SOLIDS OR LIQUIDS BY MOUTH FOR SIX (6) HOURS PRIOR TO SURGERY. TO DO OTHERWISE MAY BE LIFE-THREATENING! I agree not to drive myself home and to have a responsible adult accompany me until I am recovered from my medications. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

