Oral & Maxillofacial Surgery Specialists, P.C.
8580 Scarborough Dr. Suite #240
Colorado Springs CO 80920

PATIENT REGISTRATION

PLEASE PRINT COMPLETE ANSWERS TO ALL QUESTIONS. This is a confidential record.

Patient Name: *First:* Peter *Middle:* r *Last:* Strand **Date** February 20, 2018 7:33 pm

Title **Email:** strand_peter@hotmail.com **Date of Birth:** 04/27/1965

SSN# **Telephone:** 9075237286 **Cellphone:**

Residence Address:

City: **State:** **Zip**

Occupation: **Employer/School:** **Work Telephone:** [workphone]

Parent/Guardian (if minor): [parent] **Home Phone Number:**

Address **SSN#**

Occupation: **Employer/School:** **Work Telephone:**

Insurance Information:

Dental Insurance Co: **Subscriber:** **Birthdate**

ID Number: **SSN:** **Group Number:**

Secondary Dental Insurance Co: **Subscriber:** **Birthdate**

ID Number: **SSN:** **Group Number:**

Medical Insurance Co: **Subscriber:** **Birthdate**

ID Number: **SSN:** **Group Number:**

Secondary Medical Insurance Co: **Subscriber:** **Birthdate**

ID Number: **SSN:** **Group Number:**

Employer:

Person to notify in Case of Emergency:

Name: **Relationship:**

Address: **Home Phone Number:**

City: **Zip:** **Work Phone Number:**

Name of person or doctor who referred you to this office:

Have you or has any member of your family ever been a patient in our office prior to today? no

If yes, name of patient and approximate date of treatment:

Please complete both sides of this form

Medical and Dental History

Physician's Name Date of last physical exam

HEART PROBLEMS: No
MURMUR/VALVULAR DEFECTS: No
RHEUMATIC FEVER No
CONGENITAL HEART DISEASE No
HEART ATTACK No
CHEST PAIN No
HIGH BLOOD PRESSURE No
FREQUENTLY SWOLLEN ANKLES No
SHORTNESS OF BREATH No
LUNG DISEASE/PERSISTENT COUGH No
PNEUMONIA No
SMOKE OR CHEW TOBACCO No
ALCOHOL OR RECREATIONAL DRUGS No
ASTHMA, HAY FEVER OR ALLERGIES No
STROKE OR TIA No
THYROID DISEASE No
FREQUENT SORES IN MOUTH No
GLAUCOMA No
FAINTING SPELLS No
EPILEPSY, CONVULSIONS, SEIZURES No
DIABETES No
LIVER DISEASE (HEPATITIS /JAUNDICE/CIRRHOSIS) No
KIDNEY DISEASE No
STOMACH ULCER/GASTRO/ESOPHAGEAL REFLUX No
VENEREAL DISEASE No
BLEEDING PROBLEMS/ANEMIA/BLOOD THINNER BRUISING No
ARTHRITIS No
REACTION TO ANESTHESIA (ANY RELATIVES) No
RADIATION THERAPY No
MALIGNANCIES No
ARE YOU PREGNANT/BREAST FEEDING No
DO YOU WEAR CONTACT LENSES No
SINUS OR NASAL PROBLEM No
DO YOU PLAY A WIND INSTRUMENT No

Are you allergic to latex(rubber gloves, balloons, elastic)? No

Have you ever been hospitalized or had previous surgeries? No

If yes, explain:

Are you allergic to or had a reaction to drugs/medications (penicillin, sulfa)?

If yes, explain:

Are you taking or have you taken Fosamax, Prolia, Xgeva, Zometa, Boniva, Actonel, Reclast or Prolia? No

Are you in Good Health? No

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

Do you smoke, use recreational drugs or Marijuana? No

Please describe any current medical treatment, impending operations or any other medical or dental information not noted above that my possibly affect your treatment:

Dentist Name:

Date of last dental exam:

Any previous complications with dental treatment? No

If yes, explain

Do you clench or grind your teeth? No

Any pain in or around the ears? No

Does your jaw pop, click or grind? No

If so, please describe

Additional comments

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

X _____/_____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY SIGNATURE OF DOCTOR DATE

MEDICAL UPDATE: I have read my health history dated ____/_____/____ and confirm that it adequately states past and present conditions.

DATE EXCEPTIONS OR CHANGES PATIENT SIGN DOCTOR