# Oklahoma Wisdom Teeth Center

PATIENT REGISTRATION FORM

**(PLEASE PRINT)**

NAME (first, mid, last) _____Goes by_____

DATE OF BIRTH_____/_____/_____ AGE_____ SEX_____ S.S.# _____-- _____ -- _____

HOME ADDRESS_____City_____State_____Zip_____

TELEPHONE home_____work_____cell_____

Is patient a full time student? _____ Attending: _____Grade/year? _____

Employer_____Occupation_____

**Personal Dentist**_____**Orthodontist**_____

**Emergency contact** _____ Relationship_____ Phone #_____

Single ( ) Widowed ( ) Married ( ) Name of spouse _____# children _____

Spouse's Employer_____ Spouse's occupation_____

Church/Religious preference_____

**Referred By:** Dentist ( ) Friend ( ) Phone Book ( ) Insurance Co. ( ) Other _____

**Have we had the privilege of treating your family members? If yes, who?**_____

## Insurance Information

Medical_____ Dental _____

Holders Name_____ Holders Name _____

Holders DOB_____ Holders DOB _____

Holders SS#_____ Holders SS#_____

**Authorization to Release Information:**
I authorize Oklahoma Wisdom Teeth Center to furnish information to my insurance carrier concerning my condition and/ or treatment.

**X**_____ **Date**_____

**Assignment of Benefits:**
I assign to Lloyd A Hudson, DDS, MD and/or Oklahoma Wisdom Teeth Center all payments for dental/medical services rendered to myself or any dependents.

**X** _____ **Date**_____

**Responsibility of Doctors Charges**
I understand that I am responsible for any amount not covered by insurance.

**X**_____ **Date**_____

## Primary Responsible Party (if other than patient)

Name_____ Relationship to patient: Spouse Mother Father Other

Birth date _____/_____/_____ S.S. # _____-- _____ -- _____ Employer _____ Wk #_____

HOME ADDRESS_____City_____State_____Zip_____

# PATIENT HEALTH HISTORY

Your medical history is an **extremely important** part of your treatment plan. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately.

List **all prescription drugs** you are taking**:** _____
_____
_____
_____
List any **non-prescription drugs** you take (aspirin, herbal medicines, etc.)_____
_____

List all **medications** to which you are **allergic** _____
_____
**List the specific allergic reaction to the medication(s)**_____
List any **contact allergies** including **latex** or other products_____

How is your **general health**? ( ) poor ( ) fair ( ) good ( ) excellent Current height _____ Current weight _____
Please list any **operations** you have had, including date performed.
_____

Describe any **difficulties** you have had with **anesthesia**_____

Do you use **tobacco**? _____ If so, what form and how much?_____

Do you drink **alcohol**? Please check one: ( ) none ( ) occasional ( ) moderate ( ) heavy

Are you under a **doctor's care**? YES ( ) NO ( ) If yes, who? _____

What are you being treated for? _____

**WOMEN**: Are you **pregnant, breastfeeding, or is there a chance you may be pregnant?**_____
**WOMEN** on birth control: I am informed and agree to use an additional form of birth control or abstain from sexual intercourse while taking antibiotics. **Patient Signature X**_____

**Please review this list and check "Yes" or "No" to anything applicable.**

| Yes | NO | | Yes | NO | |
|---|---|---|---|---|---|
| ( ) | ( ) | Heart disease/heart attack (**if yes give dates and treatment**) _____ | | | |
| ( ) | ( ) | Heart murmur | ( ) | ( ) | Glaucoma |
| ( ) | ( ) | Damaged/artificial heart valves | ( ) | ( ) | Unusual bleeding |
| ( ) | ( ) | Chest pain (**if yes, how often**?)_____ | ( ) | ( ) | Diabetes (**insulin or non-insulin** dependent/pill) **Please Circle** |
| ( ) | ( ) | Rheumatic fever | ( ) | ( ) | Seizure disorder (epilepsy) |
| ( ) | ( ) | High blood pressure | ( ) | ( ) | Cancer or tumor |
| ( ) | ( ) | Stroke (**if yes, when**)_____ | ( ) | ( ) | Radiation or Chemo (if yes for what and when) _____ |
| ( ) | ( ) | Asthma (if yes, do you have an inhaler?) _____ | ( ) | ( ) | Depression/psychological disorder |
| ( ) | ( ) | Breathing problems/short of breath | ( ) | ( ) | HIV |
| ( ) | ( ) | Hepatitis: A; B; C; Other, **Please Circle** | ( ) | ( ) | Thyroid problems |
| ( ) | ( ) | TMJ or jaw muscle problems | | | |
| ( ) | ( ) | Joint replacement | | | |
| ( ) | ( ) | Fainting spells (when nervous or at the sight a of needle) | | | |

**Any medical or dental issues not covered above?** _____

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