Oklahoma Wisdom Teeth Center

PATIENT REGISTRATION FORM

(PLEASE PRINT)

NAME (first, mid, last) _____Goes by_____

DATE OF BIRTH_____/_____/_____ AGE_____ SEX_____ SS# _____-- _____ -- _____

HOME ADDRESS_____City_____State_____Zip_____

TELEPHONE _____ EMAIL _____

Emergency contact _____ Relationship_____ Phone #_____

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

Employer_____Occupation_____

Personal Dentist_____Orthodontist_____

Are you; Single ( ) Widowed ( ) Married ( ) Spouse's Name_____# children _____

Spouse's Employer_____ _____ Spouse's occupation_____ _____

Church/Religious preference_____ **Pharmacy** _____

Referred By: Dentist ( ) Friend ( ) Internet ( ) Insurance Co. ( ) Other _____

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

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_____

Insurance Information

Medical_____ Dental _____

Holders Name_____ Holders Name _____

Holders DOB_____ Holders DOB _____

Holders SS/ID#_____ Holders SS/ID#_____

I authorize Oklahoma Wisdom Teeth Center to **RELEASE MEDICAL INFORMATION** to my insurance carrier.

I authorize direct **ASSIGNMENT/PAYMENT OF BENEFITS TO LLOYD A HUDSON, DDS MD** AND/OR **OKLAHOMA WISDOM TEETH CENTER** for all dental/medical services rendered to myself or my dependents**.**

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES, not paid by insurance, regardless of insurance coverage.

X_____ Date_____

PLEASE CONTINUE ON THE BACK

PATIENT HEALTH HISTORY

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 it possible you may be pregnant?** Yes / No (circle one, sign &date below)
Patient Signature X_____ Date_____

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_____ Date_____

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

Yes NO

( ) ( ) Heart disease/heart attack (**if yes give dates and treatment**) _____
( ) ( ) Heart murmur
( ) ( ) Damaged/artificial heart valves
( ) ( ) Chest pain (**if yes, how often**?)_____
( ) ( ) Rheumatic fever
( ) ( ) High blood pressure
( ) ( ) Stroke (**if yes, when**)_____
( ) ( ) Asthma (if yes, do you have an inhaler?) _____
( ) ( ) Breathing problems/short of breath
( ) ( ) Hepatitis: A; B; C; Other, **Please Circle**
( ) ( ) TMJ or jaw muscle problems
( ) ( ) Fainting spells (when nervous or at the sight of a needle)
( ) ( ) Glaucoma
( ) ( ) Unusual bleeding
( ) ( ) Diabetes (**insulin or non-insulin** dependent/pill) **Please Circle**
( ) ( ) Seizure disorder (epilepsy)
( ) ( ) Cancer or tumor
( ) ( ) Radiation or Chemo Date:_____for: _____
( ) ( ) Depression/psychological disorder/anxiety
( ) ( ) HIV
( ) ( ) Thyroid problems
( ) ( ) Joint replacement Date:_____

Any medical or dental issues not covered above?

_____

_____

Thanks for taking the time to fill out your patient paperwork so thoroughly! We appreciate your efforts!