DEERPATH
DENTAL SPECIALISTS
ORAL & MAXILLOFACIAL SURGERY

10 Phillip Road, Suite 117, Vernon Hills, IL 60061, 847-918-1900
www.deerpathdental.com

PATIENT REGISTRATION FORM

(Please complete both sides)

Name _____ Nickname _____

Age _____ Date of Birth _____ If minor, parent or legal guardian _____

Social security number _____ ❑ Married ❑ Single ❑ Widowed ❑ Divorced Name of spouse _____

Address _____

City _____ State _____ Zip _____ Phone _____

Occupation _____ Business Phone _____

Employer's name and address _____

Spouse's business and phone _____

Closest relative _____ Phone _____

Have you ever been a patient in our office _____ Who referred you to our office _____

Dentist's name _____ Phone _____

Physician's name _____ Phone _____

Who is responsible for your bill and will pay this account _____

Method of payment: ❑ Cash ❑ Check ❑ Bank charge _____ ❑ Charge card _____

Card number _____ Exp. date _____

Dental insurance company _____ Policy number _____

Medical insurance company _____ Policy number _____

PATIENT HEALTH QUESTIONNAIRE

Circle any of the following which you have had

Heart trouble/attack	Emphysema	Chronic headaches
Chest pain	Chronic cough	Anemia
High/low blood pressure	Tuberculosis	Kidney problems
Heart murmur	Endocrine Abnormalities	Porphyria
Circulatory problems	Thyroid condition	Ulcers
Stroke	Diabetes	Arthritis
Rheumatic fever	Hepatitis/liver trouble	Venereal disease
Shortness of breath	Jaundice	Glaucoma
Asthma	Excess weight loss/gain	Malignancy
Sinus problems	Psychiatric treatment	Chemotherapy
Bronchitis	Fainting tendency	Radiation therapy

Other illnesses - or diseases _____

PATIENT REGISTRATION FORM *(Continued)*

Is your general health good ..... Yes No

Have you seen or been under the care of a physician during the past two years ..... Yes No

If yes, for what reason _____

List diseases, illnesses operations, hospitalizations within the past five years _____

_____

Have you taken any drugs or medications at present or within the past year ..... Yes No

If yes, please list .....

Are you allergic to any medicines, drugs or foods ..... Yes No

If yes please list _____

Are you presently taking steroids, blood thinners, or insulin ..... Yes No

Have you ever had any excessive or abnormal bleeding ..... Yes No

Have you or a member of your family ever had a complication from a general anesthetic ..... Yes No

Have you ever had a complication from a local anesthetic ..... Yes No

Women: Are you pregnant ..... How many months _____ Yes No

Do you smoke ..... How much _____ _____ Yes No

Do you drink alcoholic beverages ..... How much _____ Yes No

Do you or have you ever taken narcotics ..... Yes No

Are you wearing dentures ..... Yes No

Are you wearing contact lenses ..... Yes No

CONSENT FORM

Dear Patient.

Following oral surgery, as any surgery, there are postoperative reactions which may occur. We will do our best to make your postoperative experience a pleasant one. In addition, we feel it is our duty to provide you with the following recitation of postoperative reactions, even though the chances of their occurrence as a significant problem is decidedly minimal.

1. Mandibular and/or lingual nerve paresthesia, temporary or permanent. (Numb or tingling lip, chin, gums, tongue, cheek, or teeth)
2. Pain, swelling, stiffness, bleeding, bruises, discoloration.
3. Nausea, vomiting, and allergic reactions.
4. Injury to other teeth and/or restorations.
5. Infection.
6. Thrombophlebitis.
7. Maxillary sinus involvement.
8. Jaw fracture and delayed healing.
9. Change in the occlusion and/or temporomandibular joint function.

The procedure to be performed has been explained to me, and I understand what is to be done. The possible side effects, complications and alternative modes of treatment: if any, have also been explained to me. This is my consent to the oral surgery indicated on the surgery record and to any other surgery deemed necessary or advisable in conjunction with the planned operation. I also consent to the use of local or general anesthesia depending on the judgment of Drs. Adilman, Katin, Lubar, LTD.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lark of awareness and coordination which could be increased by the use of alcohol or other drugs. I have been advised, understand and agree not to operate any vehicle or hazardous devices for at least 24 hours or until fully recovered from the effects of the anesthetic, medication, and drugs that may have been given me in the office.

I hereby authorize the release of any photographs taken before, during, after or in any way connected with my oral and maxillofacial surgery for professional educational purposes.

The above has been read to/by me and I fully understand its meaning.

Signature _____ Witness _____ Date _____

Signature _____ Witness _____ Date _____

Signature _____ Witness _____ Date _____