

PATIENT REGISTRATION & HEALTH HISTORY

Welcome to Georgia Facial & Oral Surgery. Please complete the following confidential information:

Referred by: _____

Reason for Visit: _____

Has anyone in your family ever been seen by Dr. Grant Hogan? _____ Whom? _____

Date: _____ Email: _____

Patient's Name: _____ Male Female
Last First MI

Patient's Date of Birth: _____ Age: _____ Patient SSN #: _____

Address: _____
Street City State Zip

Home Phone: () _____ Cell Phone: () _____

Employer: _____ Work Phone: () _____

Married Single Divorced Student School: _____

Spouse's Name: _____ Work: () _____
Last First MI

GUARANTOR INFORMATION (If different from patient)

Parent/Guarantor: _____ Relationship to patient: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: () _____ Work: () _____

Employer: _____ SSN #: _____ DOB _____

INSURANCE/PAYMENT INFORMATION

Please check the payment method most convenient for you: Check or Cash VISA/MC AMEX Discover

Primary Insurance Dental Medical Secondary Insurance Dental Medical

Insurance Co.: _____ Insurance Co.: _____

Subscriber's Name: _____ Subscriber's Name: _____
Last First Last First

Male Female Relation to patient _____ Male Female Relation to patient _____

Date of Birth: _____ SSN #: _____ Date of Birth: _____ SSN #: _____
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Group #: _____ Group #: _____

ASSIGNMENT & RELEASE

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and that payment or payment arrangements must be made in accordance with terms of the Financial Policy of Georgia Facial & Oral Surgery (GFOS), which is expressly made a part of this agreement and I acknowledge receiving and reading a copy of the Financial Policy.

I authorize payment of benefits to GFOS for services rendered under the terms of my insurance policy, but not to exceed the balance due of my account and for GFOS to release any medical or other information necessary to process insurance claims. I further authorize photocopies of this form to be valid as the original.

I acknowledge GFOS has made available their Notice of Privacy Practices according to 1996 HIPAA legislation. I have been given the opportunity to ask any questions I may have regarding this notice.

X _____ DATE _____

HEALTH HISTORY

Patient's Name _____

Physician's Name _____

Phone # _____

Dentist's Name _____

Phone # _____

Please answer all questions:

All responses are kept confidential

1. Are you having pain or discomfort at this time? Y N
2. Do you feel very nervous about having dental treatment? Y N
3. Have you ever had a bad experience in the dental office? Y N
4. Are you in good health? Y N
5. Has there been any change in your general health in the past year? Y N
6. Date of last physical exam _____
7. Are you now under a physician's care for a particular problem? Y N
8. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: Y N

- G. Insulin or Oral Anti-Diabetic drugs? Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Reclast, Aredia, Zometa) ? Y N
- J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

9. Height _____ Weight _____

10. DO YOU HAVE OR HAVE YOU EVER HAD:

- A. Rheumatic Fever or Rheumatic Heart Disease? Y N
- B. Congenital Heart Disease? Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Failure, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Scarlet Fever?) Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
- E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness Y N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N
- G. Liver Disease (Jaundice, Hepatitis)? Y N
- H. Kidney Disease? Y N
- I. Diabetes? Y N
- J. Thyroid Disease (Goiter)? Y N
- K. Arthritis? Y N
- L. Stomach Ulcers or Colitis? Y N
- M. Glaucoma? Y N
- N. Osteoporosis Y N
- O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
- O. Radiation (X-ray) treatment for Cancer? Y N
- P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
- Q. Sinus or Nasal problems? Y N
- R. Any disease, drug or transplant operation that has depressed your immune system? Y N

11. ARE YOU USING ANY OF THE FOLLOWING:

- A. Antibiotics? Y N
- B. Anticoagulants (Blood Thinners)? Y N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
- D. High Blood Pressure medications? Y N
- E. Steroids (Cortisone, etc.)? Y N
- F. Tranquilizers Y N

12. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

- A. Local Anesthesia (Novocain, etc.)? Y N
- B. Penicillin or other antibiotics? Y N
- C. Sedatives, Barbiturates? Y N
- D. Aspirin or Ibuprofen? Y N
- E. Codeine or other pain killers? Y N
- F. Latex or Rubber Products? Y N
- G. Other allergies or reactions? Please, list Y N

13. Do you smoke or chew Tobacco? Y N
How much per day? _____
14. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
15. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Y N
16. Have you had any serious problems associated with any previous dental treatment? Y N
17. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
18. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
19. Do you wish to talk to the doctor privately about anything? Y N

20. FOR WOMEN ONLY

- A. Are you Pregnant, or **is there any chance** you might be Pregnant? Y N
- B. Are you nursing? Y N
- C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. By signing below, I acknowledge that this information is truthful.

_____ Date

_____ Signature of Person Completing Health History

_____ Printed Name