WESTSIDE ORAL SURGERY, PC

Christopher J. Larmour, DMD
Board Certified

Practice Limited to Oral and Maxillofacial Surgery

PATIENT REGISTRATION

Today's Date_____ **BIRTHDAY** _____ Sex _____

Patient's name _____ **SS#** _____
LAST FIRST M.I.

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____ Business Phone _____

Patient Employed By _____ How Long? _____

Employer's Address _____ Work Phone _____

Who is financially responsible? (If not the patient) _____ **BIRTHDATE** _____ **SS#** _____

Relationship to Patient? _____ Home Phone _____

Home Address _____

Employer's Name and Address _____ Work Phone _____

Whom may we thank for your referral? _____ Email _____

INSURANCE INFORMATION

Prior to treatment, does your insurance require a Pre-Authorization? ❑ YES ❑ NO

DENTAL INSURANCE	MEDICAL INSURANCE
Insurance Co. _____	Insurance Co. _____
Employer _____	Claims Address _____
Policy Holder's Name _____	Employer _____
Policy Holder's Birthdate _____	ID# _____
Policy Holder's SS# _____	Group# _____
SECONDARY DENTAL	**SECONDARY MEDICAL**
Insurance Co. _____	Insurance Co. _____
Employer _____	Claims Address _____
Policy Holder's Name _____	Employer _____
Policy Holder's Birthdate _____	ID# _____
Policy Holder's SS# _____	Group# _____

HEALTH HISTORY

Please Note — All information is held in strict confidence.

Referring Dentist _____ Phone # _____

Referring Orthodontist _____ Phone # _____

Family Physician _____ Phone # _____

What brings you to our office today? _____

Emergency Contact _____ Phone # _____

Are you presently under a physician's care? ❑ YES ❑ NO

If Yes, what is the condition being treated? _____

***Have you taken aspirin within the last 7 days? ❑ YES ❑ NO**

Are you taking or have you ever taken Actonel, Fosamax, Reclast, or Prolia? ❑ YES ❑ NO

Please list all medications you are now taking:

Medication Dosage Why

LIST ALL MEDICATIONS OR FOODS YOU ARE ALLERGIC TO:

❑ Penicillin ❑ Sulfa ❑ Aspirin

❑ Codeine ❑ Novacaine ❑ Latex

❑ None

Others _____

HABITS – AMOUNTS

Smoke? ❑ YES _____ Packs ❑ NO

Alcohol? ❑ YES _____ Per day ❑ NO

Drug Use? ❑ YES _____ ❑ NO

Have you ever had a problem with drugs or alcohol? ❑ YES ❑ NO

Others _____

You're Almost Through: Please Turn Over and Complete Side Two

HEALTH HISTORY – Cont'd

Please Check Yes or No

GENERAL	YES	NO
Tire easily, Weakness	❑	❑
Marked Weight Change	❑	❑
Persistent Fever	❑	❑
"Have Taken Weight Loss Products (e.g. Phen-Phen)	❑	❑

SKIN		
Rashes, Hives	❑	❑
Changes in Skin Color	❑	❑

EYES		
Eye Problems	❑	❑
Glaucoma	❑	❑

EARS		
Loss of Hearing	❑	❑
Ear Infection	❑	❑ s

NOSE		
Frequent Nose Bleeds	❑	❑
Sinus Problems	❑	❑

THROAT		
Frequent Sore Throat	❑	❑
Post Nasal Drip	❑	❑
Cleft Palate	❑	❑

ENDOCRINE		
Diabetes	❑	❑
Thyroid Problems	❑	❑
Other Gland Problems	❑	❑

NERVOUS SYSTEM	YES	NO
Stroke	❑	❑
Frequent Headaches	❑	❑
Convulsions/Epilepsy	❑	❑
Numbness/Tingling	❑	❑
Dizziness/Fainting	❑	❑
Nerve Problems	❑	❑
Head Injury	❑	❑
Psychiatric Treatment	❑	❑
Emotional Problems	❑	❑

CARDIOVASCULAR		
Mitral Valve Prolapse	❑	❑
Rheumatic Fever	❑	❑
Any Heart Disease	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Chest Pain/Discomfort	❑	❑
Congenital Heart Disease	❑	❑
Artificial Heart Valve	❑	❑
Pacemaker	❑	❑
Scarlet Fever	❑	❑
Heart Surgery	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑

RESPIRATORY		
Asthma	❑	❑
Emphysema	❑	❑
Bronchitis	❑	❑
Pneumonia	❑	❑
Persistent Cough	❑	❑
Sleep Apnea	❑	❑

MUSCULOSKELETAL	YES	NO
Arthritis/Rheumatism	❑	❑
Broken Bones	❑	❑
Artificial Joints/Pins/Parts/Implants	❑	❑
Osteoporosis/Osteopenia	❑	❑

DIGESTIVE		
Changes in Appetite	❑	❑
Black, Bloody or Pale Stools	❑	❑
Jaundice	❑	❑
Hepatitis	❑	❑
Stomach Ulcers	❑	❑
Liver Disease	❑	❑

URINARY		
Kidney Disease	❑	❑
Kidney Transplant	❑	❑
Venereal Disease	❑	❑
Other	❑	❑

BLOOD		
Bleeding Problems	❑	❑
Blood Disorder	❑	❑
Sickle Cell	❑	❑
Anemia	❑	❑
HIV	❑	❑
Other	❑	❑

OTHER		
Radiation Treatment	❑	❑
Tumors/Growths	❑	❑
Cancer	❑	❑
Tuberculosis	❑	❑

All Operations or Surgeries: Year

_____

_____

Is there anything else you feel we should know about? _____

_____

_____

_____

FAMILY HISTORY	YES	NO
Cancer	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Sickle Cell	❑	❑

WOMEN ONLY

ARE YOU PREGNANT NOW? ❑ YES ❑ NO ❑ MAYBE
ARE YOU TAKING THE BIRTH CONTROL PILL? ❑ YES ❑ NO
ARE YOU CURRENTLY BREAST FEEDING? ❑ YES ❑ NO

IMPORTANT: Antibiotics (Penicillin, Erythromycin, etc.), which may be prescribed after treatments, may cause the birth control pill to be ineffective. Other methods of contraception are recommended for the duration of the affected cycle.

Nearest Relative Not Living With You

_____

Address_____

_____

_____

Phone_____

A NOTE OF THANKS:

Thank you for taking the time to provide us with your health history and insurance information. We are glad you chose our office for your current needs. Our friendly staff will help you relax and inspire your confidence in having made the right choice to come here. All treatments use the latest and safest technology available. Be assured we will provide you with the best care and lots of TLC. We hope you'll be pleasantly surprised.

I am 18 years of age or older, and to the best of my knowledge all the preceding answers are true and correct.:

Signature:_____

Sincerely,

The Doctors & Staff of
WESTSIDE ORAL SURGERY, PC