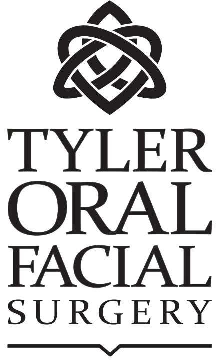


PATIENT REGISTRATION

DATE: ____________________

NAME: ____

PREFERRED NAME: (if different) ____

DOB: ________________________ **AGE:** ___________ **SS#** ___________________________________

SEX: (male) (female) **DRIVER'S LIC #** ____________________ **STATE** __________

MARITAL STATUS: (M) (S) (D) (W)

MAILING ADDRESS :

STREET ____

CITY ________________________________

STATE ________ ZIP CODE ______________

PHONE NUMBERS:

Home _______________________________

Work _______________________________

Cell _______________________________

E-MAIL ADDRESS ____

EMPLOYER

Name ____

Address ____ Phone ________________________________

PARENT/LEGAL GUARDIAN (if minor) ____

Phone ________________________________

REFERRING DENTIST/PHYSICIAN ____

PRIMARY CARE PHYSICIAN ____

EMERGENCY CONTACT PERSON NOT LIVING WITH YOU

Name ____ Relationship to the patient _________________________

Phone ________________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT ____

RELATIONSHIP TO THE PATIENT

☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Other: ______________________________

ADDRESS ____ **Phone** _____________________________

RESPONSIBLE PARTY'S SS# ______________________________ **DOB** ____________ **DL#** ____________________

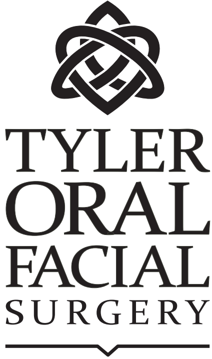
(your social security number is necessary to protect your account, even if there is no insurance involved)

I HEREBY AUTHORIZE DR. JAMES HOLTON/ DR. MAKOTO SAIGUSA/ DR. JAYSON TERRES TO PERFORM THE SERVICES THAT ARE NECESSARY IN HIS JUDGEMENT AND ANY ADDED PROCEDURE WHICH HE MAY DEEM NECESSARY FOR THE ABOVE PATIENT.

X____ ______________________________

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE RELATIONSHIP TO THE PATIENT

HEALTH HISTORY



REASON FOR OFFICE VISIT ______________________________

LIST CURRENT/PREVIOUS MEDICAL CONDITIONS: ☐ NONE ______________________________

____

____

LIST PREVIOUS SURGERIES: ☐ NONE ______________________________

____

LIST CURRENT MEDICATIONS/ HERBAL SUPPLEMENTS/ VITAMINS: ☐ NONE ______________________________

____

____

YES NO Do you have any medication or food allergies?
If so, please list ______________________________
YES NO Are you allergic to latex?
YES NO Have you or a family member ever had problems with anesthesia?
YES NO Do you smoke or chew tobacco? If so how much? ____________
YES NO Do you use illicit drugs/medication? If so list: ____________
YES NO Do you wear hearing aids?
YES NO WOMEN: Are you nursing?
YES NO Are you pregnant or planning pregnancy?
YES NO Are you taking birth control pills?

REVIEW OF CURRENT/PAST MEDICAL CONDITION

YES NO **HEART DISEASE** (heart trouble, high or low blood pressure, heart attack, heart murmur, coronary artery disease, irregular heart beat, pacemaker, heart valve replacement, rheumatic fever, etc.)
YES NO **LUNG DISEASE** (asthma, emphysema, bronchitis, tuberculosis, etc.)
YES NO Do you have a heavy, persistent cough of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum?
YES NO **LIVER DISEASE** (hepatitis, cirrhosis, etc.)
YES NO **KIDNEY DISEASE** (dialysis, kidney transplant, etc.)
YES NO **GASTROINTESTINAL DISEASE** (ulcer, gastritis, etc.)
YES NO **ENDOCRINE DISEASE** (thyroid, diabetes, steroid use, etc.)
YES NO **NEUROLOGICAL DISEASE** (stroke, seizure, paralysis, etc.)
YES NO **BLOOD DISORDER** (hemophilia, blood thinners, Coumadin/Aspirin use, anemia, etc)
YES NO **IMMUNOLOGICAL DISEASE** (history of recurrent infection, immunosuppressive medication: Prednisone, Methotrexate, etc.)
YES NO **MENTAL DISEASE** (dementia, bipolar disease, schizophrenia, etc.)
YES NO **MUSCULOSKELETAL DISEASE** (Arthritis, Osteoporosis, bisphosphonate use: Fosomax, Boniva, Reclast)

If you answered yes to any of the above questions or have a condition that is not listed, please explain:

____

____

I understand that Texas law provides, and I agree, that if any healthcare worker is exposed to my blood or any bodily fluid, to allow the Clinic to perform test(s) on my blood or other bodily fluid to determine the presence of any communicable disease, including, but not limited to, Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS) and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of the Clinic. I understand that the results of test taken under these circumstances do not become a part of my medical records.

ADVANCED DIRECTIVES: *(i.e., Living Will, Medical Power of Attorney)*

☐ I DO NOT have Advanced Directives.
☐ I DO have Advanced Directives and will provide a copy to Tyler Oral and Facial Surgery Center in the event that I am scheduled to have surgery.

To the best of my knowledge, the above information is true and correct:

X______________________________ ______________________________
PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE RELATIONSHIP TO THE PATIENT