

Oral & Maxillofacial Surgery of Greater Grand Rapids, PLLC
Dr. Bradley VanHoose DDS, MS
Patient Registration Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Other _____

Sex: Male _____ Female _____ Age _____ Date of Birth _____ Drivers Lic. # _____

Employer _____ Business Phone # _____

Dentist _____ Referring Doctor _____

Emergency Contact _____ Phone # _____

Responsible Party: (If minor or legal guardian) Relationship To Patient _____

Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Drivers Lic. # _____ Soc. Sec. # _____

Employer _____ Employer Phone # _____

Primary Dental Insurance:

Insurance Co. _____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Address if different than patients _____

Secondary Dental Insurance:

Insurance Co. _____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Primary Medical Insurance:

Insurance Co. _____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Address if different than patients _____

Secondary Medical Insurance:

Insurance Co. _____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Name of High School or College _____ Full _____ Part Time _____

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Medical History:

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Are you under any treatment now? Yes No If yes, describe _____

Have you ever had a problem with anesthesia? Yes No If yes, describe _____

Are you taking any medication? (including non-prescription medication)

Yes No If yes, describe _____

Do you use tobacco? Yes No Do you use controlled substance? Yes No Do you wear contact lenses? Yes No

Persistent cough or throat clearing not associated with a known illness lasting more then (3) weeks? Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

Are you allergic to or have you had any reactions to medications, latex or metals? Yes No

If yes, describe _____

Dental History:

Dentist Name _____ Date of Last Visit _____

Do you feel any pain now in your mouth, teeth or jaw areas? Yes No If yes, describe _____

Have you had any head, neck or jaw injuries? Yes No If yes, describe _____

Are you experiencing or have you experience any of the following problems in your jaw?

Clicking? Yes No Pain? Yes No Difficulty opening or closing? Yes No

Do you clench or grind your teeth? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had any prolonged bleeding following extractions? Yes No

Do you have any sores or lumps on or in your mouth? Yes No

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Authorization and Release:

I certify that I have read and understand all of the information contained in this form to the best of my knowledge. That all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the oral surgeon to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the oral surgeon or practice insurance benefits otherwise payable to me. I understand that my dental/medical insurance carrier may pay less than the actual amount for services rendered on behalf of myself or dependants.

*If you have any questions or need assistance, please ask us and we will be happy to help. **

Do not sign or date this form until it has been reviewed by our office staff or oral surgeon.

Please print name

X _____ Date: _____
Signature of patient (or parent/guardian if minor)

For office use only:

Date form completed: _____ Reviewed by: _____

Notes: _____

Oral Surgeon Comments:

Oral Surgeon: _____ Date: _____

* This on-line form is available for you to download, print, and fill out at your convenience. Please fill out completely (in ink) and bring it with you at your scheduled appointment time. To safeguard your personal and health information **do not** E-mail, Fax or electronically transmit this information to our office or any third party. Thank you.