PATIENT REGISTRATION

Patient Information

Whom may we thank for referring you to our office? _____ Date _____

Preferred Name _____

Patient Name _____ Age _____ Birthdate _____ (Circle) M or F
First M.I. Last

Residence &
Mailing Address _____
Street City State Zip

U.S. Citizen? Yes No Driver's License No. _____ **Phone Numbers:**
State

Employer _____ Occupation _____ Home: _____

Years Employed _____ Social Security No. _____ Cell: _____

Email _____ Work: _____

Responsible Party Information

(Please complete this section if someone other than patient will be paying the bill.)

Person Responsible _____ Age _____ Birthdate _____ M or F
First M.I. Last

Residence &
Mailing Address _____
Street City State Zip

Relationship
To Patient _____ Driver's License No. _____ **Phone Numbers:**
State

Employer _____ Occupation _____ Home: _____

Years Employed _____ Social Security No. _____ Cell: _____

Email: _____ Work: _____

Insurance Information

Primary Dental Insurance _____
Policy Holder Birthdate ID/SSN # Grp #

Insurance Company _____
Name of Insurance Address Phone Number

Secondary Dental Insurance _____
Policy Holder Birthdate ID/SSN # Grp #

Insurance Company _____
Name of Insurance Address Phone Number

PATIENT REGISTRATION

(CONTINUED)

Medical Information

Name of Physician _____ Phone Number _____

Medical Insurance _____

Policy Holder | Birthdate | ID/SSN # | Grp #

_____ _____

Name of Insurance | Address | Phone Number

Person to contact if unable to reach you directly

Name of Friend or Relative
(*not living with you)* _____

First | Last | Relationship

Residence & Mailing Address _____

Street | City | State | Zip

Home Phone # _____ Cell Phone # _____

Assignment and Release

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment directly to Summit Oral Surgery & Implants/Dr. Jeffrey Burstein DDS, MD, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf, or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I authorize the oral surgery staff to perform the necessary services I may need, including but not limited to examination and x-rays.

_____

Patient's (or Legal Guardian) Signature Date

_____

Printed Name

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

DENTAL HISTORY

Name of General Dentist:_____Telephone Number: _____

Date of last visit:_____

What are your chief dental problem /complaints?_____

_____

If you could improve your current dental condition, what would you like to be done?_____

_____

Do you grind your teeth? Yes / No Have you ever been treated for periodontal gum disease? Yes / No

Do you have dry mouth? _____

Have you ever had surgery on your jaw? _____

Do you have any jaw joint implants? _____

Have you ever had a reaction to dental injections? _____

Are you under the care of a dentist for any dental problems? _____

Do you wear dentures?_____If yes, do you enjoy wearing dentures? _____

Do you have any dental bridges or removable dental appliances? _____

Do you have any swelling, bleeding, discoloration or lumps in your mouth? _____

Have you ever worn or been told to wear a dental splint? _____

Are your teeth sensitive or painful? _____

Do you have pain in or near your ears? _____

Do you have unusual sounds in your ears or jaw when opening or closing your mouth? _____

Summit Oral Surgery & Implants
3332 N Lombard St., Ste A, Portland, OR 97217
1725 St. Helens Street, St. Helens, OR 97051
Phone: (503) 366-4248, Facsimile: (503) 296-2454

MEDICAL HISTORY

It is important that we know about your dental and medical history. Many conditions may have a direct impact on your dental treatment. We will review this questionnaire and discuss it with you in detail. Information provided is strictly confidential and will not be released without your permission.

Are you in generally good health? Circle: Yes / No

Do you have any major medical problems? Yes / No If yes, please explain in detail. _____

_____

_____

Height_____ Weight_____

Are you under care of a physician now?_____If yes, please explain in detail. _____

_____

Name of current physician:_____ Telephone Number: _____

Address of current physician _____

Have you ever had any problems with anesthesia?_____If yes, please explain in detail. _____

_____

_____

Do you have a pacemaker / defibrillator / heart stent? _____ Yes _____ No

Do you have the Implantable defibrillator card with you? _____ Yes _____ No Make/Model _____

Cardiologist Name: _____ Phone Number: _____

Have there been any changes in your health within the past 12 months? Circle: Yes / No Explain: _____

_____

Have you ever been prescribed: Aredia, Zometa, Didronel, Actonel, Skelid, Fosamax, Boniva (Idandronate), Vioxx, Reclast, Celebrex, Prednisone, Bonefos, Xgeva, Methotrexate, Rheumatrex, Trexall, or chemotherapeutic agents? If yes, please describe:_____

_____

If yes, have you ever had the above medications administered by IV? Circle: Yes / No Name of Doctor: _____

Have you ever been hospitalized, had any surgical procedures, or have had any serious illnesses within the past 5 years? Circle: Yes / No If yes, please explain in detail.

_____

_____

Have you ever made a complaint or had a bad outcome from any previous medical/dental care?
If yes, please explain in detail.

_____

_____

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Have you ever been advised by a medical doctor or dentist to have any special precautions taken when receiving any type of dental treatment?

_____

_____

Women only

	Circle
Are you pregnant or is there any chance you may be pregnant?	Yes / No
Do you have problems associated with your menstrual period?	Yes / No
Are you nursing?	Yes / No
Are you taking birth control pills?	Yes / No

Do you have or have you had any of the following conditions?

	YES	**NO**		**YES**	**NO**
Allergies (Please List*)			Infective Endocarditis		
Allergy to Any Medication (What Type of Reaction?**)			Jaundice		
Anemia			Joint Disease		
Anxiety			Kidney Disease		
Any Immune Diseases			Latex Allergy		
Arthritis			Liver Disease		
Asthma			Low Blood Sugar		
Breathing Problems			Lupus		
Cancer (Please List***)			Neurological Problems		
Chemotherapy			Organ Transplant		
Chest Pain on Exertion			Osteoarthritis		
Chronic Bronchitis			Osteoporosis		
Chronic Fatigue			Painful or Replaced Joint(s)		
Circulatory Problems			Panic Attacks		
Congenital Heart Condition (Present from Birth)			Persistent Cough (which Produces Blood)		
Damaged Heart			Psychiatric Care		
Dental Splint			Radiation Treatment		
Diabetes			Replaced Heart Valves		
Drug Treatment			Rheumatic Fever		
Emphysema			Rheumatoid Arthritis		
Epilepsy / Seizures			Shortness of Breath		
Excessive Bleeding			Sinus Problems		
Fainting			Sleep Apnea / CPAP		
Gall Bladder Problems			Stroke		
Healing Problems			Teeth Grinding		
Heart Attack			Thyroid Problems		
Heart Murmur			Tobacco Use (Any Form)		
Heart Problems (any other)			Tonsillitis		
Heart Stent			Trauma to Head/Neck		
Hepatitis			Tuberculosis		
Herpes			Ulcers / Gastric Reflux		

High or Low Blood Pressure			Use of Alcohol		
History of Alcohol			Use of Drugs		
History of Tremors			Valve Problems		
History of Tumors			Vascular Graft		
HIV-AIDS			Venereal Disease		
High Cholesterol			Any Other Condition(s) Not Listed ****		

*Allergies: _____

_____

_____

** Type of Reaction: _____

_____

_____

***Cancer: _____

_____

****Other conditions not listed: _____

_____

_____

_____

Does your physician recommend antibiotic coverage during dental treatment for your 1) heart murmur or MVD or 2) for your replaced joint? Yes_____No_____

Name of Physician:_____Telephone Number: _____

Summit Oral Surgery & Implants

PLEASE COMPLETE THE FOLLOWING FOR YOUR INITIAL APPOINTMENT

Many medications have a profound effect on the tissues of your mouth and lips. So that we may understand any interactions that you may experience, please list all medications that you are currently taking, including non-prescription items.

We will be updating your medications on an annual basis. Should you have any changes, please notify us at your next appointment.

Medications	How Often?	For What?	Amount Taken	Doctor