Desert Valley
ORAL SURGERY

Patient Registration Information

Date: _____ **Patient Birth Date:** ____/____/____ **Gender: M ( ) F ( )**

Name: _____ **Social Security #:** _____
(Last, First, MI)

Family Status: ( ) Married ( ) Single ( ) Child ( ) Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone (Home): _____ **Cell:** _____ **Email:** _____

Who is Financially Responsible for this patient? _____ _____
Name: *Phone:*

Who Can we notify in case of emergency? _____ _____
Name: *Phone:*

If we are assisting in filing insurance on your behalf, please provide insurance card, photo ID, and information below.

Insured (Subscriber) Name: _____ **DOB:** ____/____/____ **ID #:** _____

Name of Insurance: _____ **Group #:** _____ **Employer:** _____

I have medicare as a part of my medical insurance coverage: ( ) Yes ( ) No

Whom may we thank for referring you to our practice?

( ) Dental Office Name: _____ **( ) Friend/Current Patient:** _____
( ) Other _____

Reason for your visit today: _____

Have you ever had any of the following? Please check all that apply:

( ) AIDS/HIV
( ) Allergies
( ) Anemia
( ) Arthritis
( ) Angina/Chest Pain
( ) Artificial Joints/Implant
( ) Asthma
( ) Autism
( ) Blood Disease
( ) Blood Transfusion
( ) Cancer
( ) Chronic Cough
( ) Clicking/ Popping Jaw
( ) Dizziness
( ) Depressed Immune System
( ) Diabetes
( ) Epilepsy
( ) Emphysema
( ) Fainting
( ) Glaucoma
( ) Grind or Clench teeth
( ) Hay Fever
( ) Heart Valve Replacement
( ) Heart Attack
( ) Heart Surgery
( ) Heart Disease
( ) Heart Murmur
( ) Heart Palpitations
( ) Head Injuries
( ) High Blood Pressure
( ) Hepatitis
( ) Kidney Disease
( ) Liver Disease
( ) Lung Disease
( ) Mental Disorders
( ) Jaundice
( ) Ulcers
( ) Excessive Bleeding
( ) Nervous Disorder
( ) Osteoporosis
( ) Pacemaker
( ) Radiation Treatment
( ) Respiratory Problems
( ) Rheumatic Fever
( ) Seizures/Convulsions
( ) Sinus Problem
( ) Stomach Problems
( ) Stroke
( ) Thyroid Disease
( ) Tuberculosis
( ) Tumors
( ) Are you currently pregnant?
( ) Is it possible you are pregnant
( ) Are you Nursing?
( ) Other:_____

Are you using any of the following?

( ) Antibiotics ( ) Blood Thinners ( ) Asprin/Motrin/Aleve ( ) Steroids/Cortisone ( ) Insulin/Anti-Diabetic Medication

Please list any other medications you are taking including prescription medication, diet drugs, over the counter medications, herbal for holistic remedies, vitamins or minerals

_____

Have you ever used any of the following? Please check all that apply:

Bisphosphonates ( ) Fosamax ( ) Actonel ( ) Boniva
( ) Aredia ( ) Zometa (For Osteoporosis/Cancer) ( ) PhenFen

Are you allergic to or have you had an adverse reaction to any of the following?

( ) Local Anesthesia ( ) Penicillin ( ) Antibodies ( ) Sedatives ( ) Barbiturates ( ) Aspirin ( ) Ibuprofen
( ) Codeine ( ) Pain Killers ( ) Latex ( ) Rubber ( ) Sulfa ( ) Eggs ( ) Milk ( ) Other _____

Do you have any health problems that need further clarification? ( ) Yes ( ) No
If yes, Please Explain: _____

Have you ever had any complications following a dental treatment? ( ) Yes ( ) No
If yes, Please Explain: _____

Do you smoke tobacco products? ( ) Yes ( ) No
If yes, How much per day? _____

Have you ever had a past history of alcohol, chemical dependency or emotional disorders? ( ) Yes ( ) No
If yes, Please Explain: _____

Have you or immediate family members ever had a problem associated with anesthesia?
( ) Yes ( ) No
If yes, Please Explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years?
( ) Yes ( ) No
If yes, Please Explain: _____

Name of Physician: _____ Phone: _____

** If you are using oral Contraceptives, it is important to understand that antibiotics may interfere with the effectiveness of oral contraceptives, Therefore you will need to use additional forms of birth control IF an antibiotic is prescribed**

Do you wish to talk to the doctor privately about anything? ( ) Yes ( ) No

To the best of my knowledge, all of the preceding answers and information provided is true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Desert Valley Oral Surgery and Dr. Donovan Hansen DDS is not a participating provider under any state funded AHCCCS or Medicare programs. As an OPT-OUT provider with no authorization to bill for services, the charges for services rendered cannot be billed to these heath plans. As a practice, Desert Valley Oral Surgery does not accept reduced fees from the programs nor do we provide billing information. I agree any services rendered in this facility are solely my financial responsibility and I agree to make payments in full at the time of the services, unless prior arrangements have been made. I am fully aware that I have the choice to have services performed under these terms or I can choose to seek treatment with a participating provider.

In the event that any of the office staff of Desert Valley Oral Surgery is injured while performing patient treatment (i.e needle stick, puncture wound, etc.), Desert Valley Oral Surgery has my full consent to draw a blood sample for the purpose of laboratory testing, this will ensure the safety of all parties who are concerned and involved.

I _____ **represents that I am legally authorized to obtain medical services for the patient who is a minor or is under my care.**

_____ _____
Signature of patient, parent or guardian ***Date:***

_____
Signature of Doctor