New Patient Registration Package

The following forms are for new patients who will be coming to our office as well as previous patients who have not been seen by either Drs. Bird or Johnson for more than three (3) years.

Please print all the forms included. Complete the forms at home and bring them to our office at your scheduled appointment time.

If you take any medications, please bring a written list of all medications, including strength and dosage instructions to your appointment.

Important:
Minors must be accompanied by a parent or legal guardian to all consultation and surgical appointments.

Thank you and we look forward to seeing you!

Get Acquainted Questionnaire

Gerald W. Bird, D.M.D   Board Certified in Oral and Maxillofacial Surgery   Jay A. Johnson D.M.D.

Patient Information Please Print   **Today's Date: / /**

Title: Mr. Mrs. Miss Ms. Mstr. Dr. Fr. Sr.   Social Security Number:______________________

Name: ____________________________________ (Last, First, Middle Initial)   Occupation: ________________________________

Street Address: ______________________________   Employer: ________________________________

City: _____________________State: ____________   Address: __________________________________

Zip: __________ Telephone: ___________________   City: _______________State: __________________

Daytime Telephone: __________________________   Zip: _________Telephone: ____________________

Date of Birth: ________/_________/_____________   Student Status: Full-Time [ ] Part-Time [ ]

School Name: _______________________________

Marital Status: Single Married Divorced Widowed

Emergency Contact: ___________________________

Spouse: _____________________________________   Relationship: ___________ Telephone: ___________

Person Responsible for Payment If Not The Person Listed Above (Parent When Applicable)

Name: _____________________________________   Social Security Number: ______________________

Relationship To Patient: _______________________   Employer: __________________________________

Street Address: ______________________________   Address: ___________________________________

City: __________________State: _______________   City: _________________ State: _______________

Zip: __________Telephone: ____________________   Zip: __________Telephone: ___________________

Referral Information Whom May We Thank For Referring You? ______________________________

Name of Dentist: _____________________________   Did you bring x-rays with you? Yes [ ] No [ ]

City: _____________Date of Last Visit: ___________   Name of Physician: ___________________________

Other Dental Specialist(s): ______________________ (i.e. Orthodontist, Periodontist)   City: __________Date of Last Visit: _____________

Insurance Information Do You Desire To File A Claim? Yes [ ] No [ ] Dental [ ] Medical [ ] Both [ ]

Name of Insured: _____________________________   Dental Insurance Agency: ______________________

Relationship to Patient: _________________________   Address: ___________________________________

Social Security Number: _________________________   Medical Insurance Company: ___________________

Insured's Date Of Birth: _________________________   Address: ___________________________________

Health History Record

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Thus it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the Doctor or a member of the staff for assistance.

Present complaint or problem and its duration ______________________
____
____

Allergies

Penicillin______________**Codeine**________________
Aspirin_________________**Other**_________________
None Known__________________________________

Age:__________ Weight:___________ Height:_____________

Question	Yes	No	?
1. Are you now in good health?			
2. Are you now, or have you been under the care of a physician during the past 2 years?			

If so, for what condition?____

3. Date of last physical examination:____

Question	Yes	No	?
4. Have you ever been a patient in a hospital?			

Reason: ____________________ Date: __________
Reason: ____________________ Date: __________
Reason: ____________________ Date: __________
Reason: ____________________ Date: __________

5. Please list all medications you are currently taking or have taken in the last year. If none, write none

_______________ _______________ _______________ _______________
_______________ _______________ _______________ _______________
_______________ _______________ _______________ _______________
_______________ _______________ _______________ _______________

Question	Yes	No	?
A. Have you ever taken "Blood Thinners" or Steroid (Cortisone) Therapy?			
B. Are you sensitive or allergic to penicillin or any other drugs, medicines or anesthetics?			

C. If so, Please list:____

6. Do you have, or have you ever had?: (Check all that Apply)

a) heart trouble
b) high or low blood pressure
c) hear murmur
d) stroke
e) rheumatic fever
f) angina pectoris
g) chest pain
h) swollen ankles
I) shortness of breath
j) emphysema
k) persistent cough
l) asthma/bronchitis
m) blood disorder/bleeding problems
n) anemia
o) porphyria
p) kidney, liver or lung disease
q) hepatitis / jaundice
r) severe headaches
s) sinus trouble
t) nosebleeds (frequent)
u) epliepsy
V) stomach (ulcer, etc.)/ bowel problems
w) hyprethyroidism / hypothyrodism (thyroid trouble)
x) glaucoma
y) cancer
z) diabetes
aa) veneral disease
bb) drug addiction
cc) alcoholism
dd) tuberculosis
ee) arthritis
ff) scarlet fever
gg) allergies
hh) others (please indicate)

Question	Yes	No	?
7. Are you subject to any nervous disorders, fainting or dizziness?			
8. Are you subject to excessive bleeding?			
9. Have you ever had psychiatric treatment?			
10. Do you have any difficulty in opening your mouth wide? Jaws ever click or catch?			
11. Have you ever had any Orthodontic care?			
12. Have you ever had any injury to your face or jaws?			
13. Have you ever had any difficulty with past dental treatment? Explain:____________			
14. Have you ever had a local anesthetic (numbing an area)?			
15. Have you ever had any difficulty with the use of a local anesthetic ("Novocain")?			
16. Have you ever had a general anesthetic (completely asleep)?			
17. Have you or any family member experienced any problem associated with a general anesthetic or "Twilight Sleep"? Explain:____________			
18. Do you have any numbness or tingling sensation in any part of your body?			
19. Have you ever received radiation or surgical treatment for a tumor, growth or condition about your head, mouth, lips?			

20. Females: Are you pregnant?___________How many months?_____________ Are you nursing a baby?________________________
21. Do you use tobacco or smoke?_________________How much?_________________How long?____________________________

Question	Yes	No	?
22. Do you wear contact lenses?			
23. Have you had anything to eat or drink in the last 6 hours?			

24. Is there any information, not given about, that you think is important for proper health care treatment in your case? ____
____

The above medical history is accurate and current to the best of my knowledge.

Signature: ______________________________ Date: ______________