

Oral & Maxillofacial Surgery Specialists

4035 Morsay Drive
Rockford, IL 61107

D. A. Francis, DDS

S. W. Albers, DDS

Patient Registration Form

Patient

Chartnumber: _____

Social Security Number: _____

Full Name: _____

Birthdate: _____

Age: _____

Sex: _____

Address: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Referred By: _____

Dentist: _____

Physician: _____

Employer: _____

Dates Out Of Work From: _____

To: _____

Patient Illness: _____

Date of Illness: _____

Employment: _____

Date of Similar Illness: _____

Other Accident: _____

Auto Accident: _____

State: _____

Billing

Name: _____

Social Security Number: _____

Address: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Relation to Patient: _____

Employer: _____

Employer Address: _____

Primary Medical Insurance

Insurance type: _____

Name: _____

Relation to Patient: _____

Address: _____

Insurance Group: _____

Plan Name: _____

Phone: _____

Employer: _____

Birthdate: _____

Sex: _____

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Patient: _____

Secondary Medical Insurance

Insurance Type: _____

Name: _____

Relation to Patient: _____

Address: _____

Insurance Group: _____

Plan Name: _____

Phone: _____

Employer: _____

Birthdate: _____

Sex: _____

Primary Dental Insurance

Name: _____

Relation to Patient: _____

Address: _____

Insurance Group: _____

Plan Name: _____

Phone: _____

Employer: _____

Birthdate: _____

Employer Address: _____

Sex: _____

Marital Status: _____

Employment Status: _____

Secondary Dental Insurance

Name: _____

Relation to Patient: _____

Address: _____

Insurance Group: _____

Plan Name: _____

Phone: _____

Employer: _____

Birthdate: _____

Employer Address: _____

Sex: _____

Marital Status: _____

Employment Status: _____

I understand that any information acquired in the course of my examination or treatment may be discussed with, or released to, any treating medical personnel or responsible insurance company. I understand that I am responsible for payment of charges incurred during my care, and any portion not paid by a third party shall be paid by me. I hereby authorize payment of benefits otherwise payable to me, to be paid directly to Dr. Francis or Dr. Albers. I understand that any balance unpaid past 60 days(from the time of treatment) shall be subject to interest charges of 1.5% per month.

Signed(Patient or Responsible Party): _____

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Health History Form

Patient Name: _____

Date: _____

	Yes	No
Have you ever taken PhenFen or Redux for weight reduction?		
Have you had implants such as heart valves or joints placed?		
Do you have TMJ(jaw joint) problems?		
Have any blood relatives had reactions to an anesthetic?		
Have you recently taken a long-term dose of oral cortisone?		
Are you pregnant?		
Are you wearing contact lenses?		
Do you use or smoke tobacco?		
Do you use recreational drugs?		

Doctor's Comments

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

	Yes	No
Epilepsy		
Heart Murmur		
Mitral Valve Prolapse		
Heart or Chest Palpitations		
Heart Surgery		
Angina of Chest Pain		
High Blood Pressure		
Stroke		
Severe Headache and/or Dizziness		
Shortness of Breath		

	Yes	No
Persistent Cough		
Tuberculosis(TB)		
Asthma		
Hepatitis		
Stomach Ulcer		
Glaucoma		
Diabetes		
Prolonged Bleeding Tendency		
Do you wish to speak to the doctor privately?		

Please list allergies to any substance (medication, food, insect bites or stings, etc.):

Please list the medications you are taking:

Please describe any other health problems that you have:

Signed: _____

Date: _____

Health History Reviewed By:	Dr. Albers	Dr. Francis

		Date: _____