Gregory L. Shaker, D.D.S. ▪ Oral and Maxillofacial Surgeon
Exeter Oral Surgery

PATIENT REGISTRATION

NAME_____ DATE OF BIRTH_____ SS#_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE (HOME) _____ (CELL) _____ (WORK) _____

GENDER ☐ F ☐ M

EMPLOYER_____ IF FULL TIME STUDENT: SCHOOL_____

REFERRED BY_____

GENERAL DENTIST _____ PHYSICIAN _____

FINANCIAL RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT) _____

RELATIONSHIP TO PATIENT: ☐ PARENT ☐ LEGAL GUARDIAN ☐ OTHER_____

NAME_____ DATE OF BIRTH_____ SS#_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PLEASE PROVIDE US WITH YOUR CURRENT INSURANCE INFORMATION BELOW

PRIMARY DENTAL INSURANCE COMPANY NAME: _____

MEMBER ID#:_____ EMPLOYER:_____

NAME OF SUBSCRIBER:_____ DATE OF BIRTH: _____

SECONDARY DENTAL INSURANCE COMPANY NAME_____

MEMBER ID#:_____ EMPLOYER: _____

NAME OF SUBSCRIBER:_____ DATE OF BIRTH: _____

PRIMARY MEDICAL INSURANCE COMPANY NAME: _____

MEMBER ID#:_____ EMPLOYER:_____

NAME OF SUBSCRIBER:_____ DATE OF BIRTH: _____

SECONDARY MEDICAL INSURANCE COMPANY NAME:_____

MEMBER ID#:_____ EMPLOYER: _____

NAME OF SUBSCRIBER:_____ DATE OF BIRTH: _____

OUR PAYMENT POLICY

Payment is expected at the time of service. Your financial obligation for treatment is between you and this office, and is not dependent upon insurance coverage. After your financial obligation to this office has been arranged we will submit to your insurance company. A 1 ½ % monthly (18% annual) interest charge will incur on balances after 90 days. A fee may be charged for appointment missed or cancelled without advance notice of at least two business days. I herby assign all medical or dental benefits to be paid to Dr. Gregory L. Shaker I understand that I am financially responsible for all charges whether or not paid by insurance. This office has made available to me its Notice of Privacy Practices.

SIGNATURE of financially responsible party_____ **DATE** _____

METHOD OF PAYMENT: ☐ **CASH/CHECK** ☐ **MC/VISA/DISCOVER** ☐ **CARE CREDIT**

(continued on reverse side)

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

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9. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY ADVERSE REACTION TO:
   - **Any antibiotics?** ..... Y N
   - Aspirin or Ibuprofen? ..... Y N
   - Latex or rubber products? ..... Y N
   - **PLEASE LIST ALL ALLERGIES OR REACTIONS:** _____

_____

_____

10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or <u>is there any chance</u> you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

SIGNATURE: _____ **DATE** _____

Patient (if over 18)/Parent or Legal Guardian

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials
Date	Exceptions or changes	Patient's Signature	Doctor's Initials