New Patient Registration & Consent Form

Preferred Name: _____

Patient Full Legal Name: _____

Sex: ☐ Male ☐ Female **Email Address:** _____

Date of Birth: ___ / ___ / _____ **Age:** ____ **Weight:** ____ **Height:** ____ **Social Security #:** ___ – ___ – _____

Home Address: _____ **City:**_____ **State:**____ **ZIP:** _____

Primary Phone: (_____) _____ – _____ ☐ Mobile ☐ Home ☐ Work

Secondary Phone: (_____) _____ – _____ ☐ Mobile ☐ Home ☐ Work

***Name of Emergency Contact:** _____**Relationship:**_____

***Emergency Contact:** (_____) _____ – _____ ☐ Mobile ☐ Home ☐ Work

Primary *Dental* Insurance:

Insurance Provider: _____ **Group #:** _____

Employer: _____**Policy/Member ID #:** _____

Policy Holder Name: _____ **Relationship to Patient:** _____

DOB:_____ **SSN**:_____ **Insurance phone number**:_____

Primary *Medical* Insurance:

Insurance Provider: _____

Policy / Member ID #: _____**Group #:** _____

Do You Have Secondary Insurance Coverage: ☐ **Yes** ☐ **No**

Name of Referring Dentist/Physician: _____

Preferred Pharmacy Name: _____ Pharmacy Phone # _____

Pharmacy Address: _____

Oral Surgery History + Anesthesia & Sedation Screening:

Have you had previous oral surgery?	☐ **Yes** ☐ **No**
Have you had complications with dental treatment or anesthesia?	☐ **Yes** ☐ **No**
Have you ever had IV sedation or general anesthesia?	☐ **Yes** ☐ **No**
Any history of nausea or vomiting with anesthesia?	☐ **Yes** ☐ **No**
Any family history of anesthesia problems?	☐ **Yes** ☐ **No**
Do you smoke, vape, or use tobacco products?	☐ **Yes** ☐ **No**
Do you use alcohol or recreational drugs?	☐ **Yes** ☐ **No**
Have you been prescribed narcotic pain medications before?	☐ **Yes** ☐ **No**
Did the prescribed narcotics work as intended?	☐ **Yes** ☐ **No**

If you answered yes on any question, please explain:_____

Medical History, Current Medications & Allergies: *(Check all that apply)*

□ Heart Disease	□ High Blood Pressure	□ Sleep Apnea	□ Liver Disease	□ Osteoporosis
□ Diabetes	□ Bleeding Disorder	□ Asthma/COPD	□ Thyroid Disorder	□ Anxiety/Panic Disorder
□ Stroke	□ Seizure	□ Kidney Disease	□ Cancer	□ Mental Health Condition
□ Pregnant or nursing	□ Other: _____			

□ No known allergies □ Medication allergies:_____ Other: _____

Please list all medications, vitamins, and supplements you are currently taking: _____

_____

☐ I certify that I have read and understand the questions above. I acknowledge that my questions, if any, regarding the information set forth above have been answered to my satisfaction. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. **_____Initials**

☐ We make every effort to keep the cost of your care as reasonable as possible. An estimate of charges for any procedure or surgery may be provided upon request. If you have dental and/or medical insurance, we are happy to submit claims on your behalf; however, insurance is considered a method of reimbursement to the patient and is not a substitute for payment. You are responsible for all deductibles, co-insurance, and any balance not paid by your insurance carrier. You are also responsible for all collection costs, attorney's fees, and court costs, if applicable.**_____Initials**

☐ I authorize the release of information necessary to process insurance claims and authorize payment of insurance benefits directly to the doctor for services rendered. I understand that Sierra Oral & Facial Surgery is opted out of Medicare and that I am entering into a private contract for my care. **____Initials**

☐ I authorize my surgeon and designated staff to perform an oral and maxillofacial examination for diagnosis and treatment planning, including all necessary x-rays. If medically necessary, I authorize the release of information obtained during my examination and treatment to other healthcare providers and/or insurance carriers. I also permit messages to be left on my home and/or mobile phone regarding appointments. I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and that I have had the opportunity to ask questions. **_____Initials**

Signature of Patient / Parent or Guardian (if minor): _____ **Date:**_____