Piney Point Oral and Maxillofacial Surgery

Thomas M. Weil, DDS
Steve L. Koo, DDS

2450 Fondren Suite 320
Houston, Texas 77063
(713) 783-5560
www.PineyPointOMS.com

NEW PATIENT REGISTRATION

Step 1: Please complete as many form fields as possible.
Step 2: Please print and bring the form with you to your appointment.

Date: 07/13/2017

1 About You

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Preferred Name: _____ **Birthdate:** _____ **SS#:** _____

Sex: ❑ Male ❑ Female **Status:** ❑ Single ❑ Married ❑ Minor ❑ Widowed ❑ Divorced

Address: _____ **City, State:** _____ TX **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

Occupation: _____ **Physician:** _____ None

Preferred Contact Method: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Student: ❑ No ❑ Full Time ❑ Part Time **School Name:** _____

Person to contact for Emergency: _____ **Phone:** _____

Spouse/Parent Name: _____ **Occupation:** _____ **Phone:** _____

Address: _____ **City, State:** _____ **Zip Code:** _____

Is this visit related to an accident? ❑ Yes ❑ No **If yes, date of accident:** _____

Time of accident: _____ **Type of accident:** ❑ Work-related ❑ Automobile ❑ Other (list): _____

How did you learn about our practice? (provide name): _____

2 Responsible Party Information (Complete if you are the parent or guardian of the patient)

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Preferred Name: _____ **Birthdate:** _____ **SS#:** _____

Relationship to patient: _____

Address: _____ **Address 2:** _____

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

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

Occupation: _____ **Referred By:** _____ None

Preferred Contact Method: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Student: ❑ No ❑ Full Time ❑ Part Time **School Name:** _____

Are you? ❑ FT ❑ PT **If none, are you?** ❑ Retired ❑ Disabled

3 Insurance Information

PRIMARY DENTAL INSURANCE

Relation: None ← Must select relation first
Employer:
Bus. Address:
City: **State:** **Zip:**
Insurance Co. Name:
Address:
City: **State:** **Zip:**
Phone #:
Insured's Name: FIRST MI LAST
Address:
Address 2:
City: **State:** **Zip:**
Phone: **DOB:**
Insured's ID#:
Group # (Plan, Local, or Policy #)**:**
Social Security #:

SECONDARY DENTAL INSURANCE

Relation: None ← Must select relation first
Employer:
Bus. Address:
City: **State:** **Zip:**
Insurance Co. Name:
Address:
City: **State:** **Zip:**
Phone #:
Insured's Name: FIRST MI LAST
Address:
Address 2:
City: **State:** **Zip:**
Phone: **DOB:**
Insured's ID#:
Group # (Plan, Local, or Policy #)**:**
Social Security #:

4 Insurance Information

PRIMARY MEDICAL INSURANCE

Relation: None ← Must select relation first
Employer:
Bus. Address:
City: **State:** **Zip:**
Insurance Co. Name:
Address:
City: **State:** **Zip:**
Phone #:
Insured's Name: FIRST MI LAST
Address:
Address 2:
City: **State:** TX **Zip:**
Phone: **DOB:**
Insured's ID#:
Group # (Plan, Local, or Policy #)**:**
Social Security #:

SECONDARY MEDICAL INSURANCE

Relation: None ← Must select relation first
Employer:
Bus. Address:
City: **State:** **Zip:**
Insurance Co. Name:
Address:
City: **State:** **Zip:**
Phone #:
Insured's Name: FIRST MI LAST
Address:
Address 2:
City: **State:** **Zip:**
Phone: **DOB:**
Insured's ID#:
Group # (Plan, Local, or Policy #)**:**
Social Security #:

5 General Health

Have you been a patient in a hospital in the past two years? If so, for what were you hospitalized? ❑ No ❑ Yes

_____

Are you now, or have you been, under the care of a physician (including a psychiatrist) during the past two years? If so, please describe below what you were treated for? ❑ No ❑ Yes

_____

Do you wear contact lenses? ❑ No ❑ Yes
Are you now under a physician's care for a particular problem? ❑ No ❑ Yes
Have you ever had any illnesses, operations or hospitalization? ❑ No ❑ Yes
If so, describe: _____
Please briefly state your reason for today's visit: _____
Weight: _____ Height: _____ Age: _____

6 Health History

Have you ever had any of the following diseases or medical conditions or procedures?:

- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Congestive Heart Disease
- ❑ Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)
- ❑ Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)
- ❑ Seizures, Convulsions, Epilepsy, Fainting or Dizziness
- ❑ Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion
- ❑ AIDS (Acquired Immune Deficiency Syndrome)
- ❑ Liver Disease (Jaundice, Hepatitis)
- ❑ Kidney or bladder trouble
- ❑ Diabetes
- ❑ Thyroid Disease (Goiter)
- ❑ Arthritis
- ❑ Stomach Ulcers
- ❑ Glaucoma
- ❑ Cancer
- ❑ Radiation (X-ray) treatment for Cancer
- ❑ Blood disease
- ❑ Syphilis or venereal disease
- ❑ Any disease, drug or transplant operation that has depressed your immune system
- ❑ Nervous disorders
- ❑ Obstructive sleep apnea

MEDICATION & ALLERGIES:

List medicines, or drugs, you have taken during the past year and for what conditions:
(include mg doses and frequency of use)

_____

_____

_____

Have you taken cortisone or other hormone medication? If so, please list: _____ ❑ No ❑ Yes
Have you had any surgical procedures in the past? Describe below: ❑ No ❑ Yes

_____

If surgery was performed, name the surgeon: _____
Do you have prosthetic implants placed anywhere in your body: (heart valve, hip, knee, etc.) ❑ No ❑ Yes

_____

Have you had any reactions to sulfites, hay fever or any other allergies? If so, please describe: ❑ No ❑ Yes

_____

When you cut yourself, or have a tooth extracted, do you bleed so much that you have to see a doctor to have it stopped? ❑ No ❑ Yes

Have you ever had a reaction during, or following, dental treatment or oral surgery? ❑ No ❑ Yes

Are you allergic to or have you had an adverse reaction to Aspirin, sulfa, or penicillin? ❑ No ❑ Yes

Are you allergic to or have you had an adverse reaction to Codeine or other pain killers? ❑ No ❑ Yes

Do you faint easily? ❑ No ❑ Yes

Do you get short of breath easily? ❑ No ❑ Yes

Have you gained, or lost, more than fifteen pounds recently? ❑ No ❑ Yes

Do you smoke or chew Tobacco? ❑ No ❑ Yes How much smoke or tobacco you use per day? _____

Do you have any sores or growths in your mouth? ❑ No ❑ Yes

Have you ever had any serious injuries to your face or jaws? Describe: _____ ❑ No ❑ Yes

Have you had temporomandibular joint disorder or dysfunction? ("TMJ")? ❑ No ❑ Yes

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? _____ ❑ No ❑ Yes

7 For Women Only

This section is for women only, men continue below. Women, continue below when you have completed this section.

Are you pregnant? ❑ No ❑ Yes

Do you wish to have a pregnancy test? ❑ No ❑ Yes

8 Consent for Services

This section will be filled out and signed when you come to the office.

Lifetime Authorization Form for Oral/Maxillofacial and Cosmetic Surgery Services

I authorize treatment of the person above and agree to pay all fees and charges for such treatment to this practice's Patient Financial Agreement. I authorize the release of any medical information to any insurance or Medicare insurer that is necessary to process any insurance claim and to request payment of benefits, whether to myself or to this practice. I hereby assign payment of insurance benefits for services rendered by this practice, directly to the practice.

Patient's Signature: _____ **Date:** _____

Parent/Responsible Party's Signature: _____ **Relationship:** _____

Office use only:

Employee: _____ Date: _____ Chart: _____