OMSA
Michael H. Porter, DDS Board Certified
Lon R. Doles, DDS Board Certified

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES

PATIENT REGISTRATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. The information we request will help us to prepare for your visit and ensure a pleasant and smooth experience. If you have any questions Please do not hesitate to contact our office at 843-554-5003.

PERSONAL DETAILS

Last Name:			First Name:		
Middle Name:			Preferred:		
Birth date:	SS#		Gender: ☐ Male ☐ Female ☐ Other	Married: ☐ Yes ☐ No	
Work Phone:	Home Phone:		Mobile Phone:		
Email:					
Preferred contact method:	☐ Home Phone ☐ Work Phone ☐ Mobile ☐ MS/Text ☐ Email				
Preferred contact method for billing:	☐ Home Phone ☐ Work Phone ☐ Mobile ☐ MS/Text ☐ Email				
Student status if dependent over 18 (for insurance):	☐ Non Student ☐ Full-time ☐ Part-time				
Occupation:					
Dentist's Name:					
Emergency Contact Name:					
Phone Number:			Relationship to You:		
How did you hear about us?	☐ Radio ☐ Magazine ☐ News Paper ☐ Facebook ☐ Instagram ☐ Google Reviews ☐ Billboard				
	☐ Yelp Reviews ☐ Flyer/Mailer ☐ Kiss Wisdom Teeth Goodbye Campaign ☐ Other:				
Did someone other than your dentist refer you to our office? *(Please let us know their name so we can thank them!)*					

ADDRESS INFORMATION

Check box if same for entire family: ☐					
Address:					
Apartment or Unit Number:					
City:		State:		Zip:	
Home Phone:					

DENTAL INSURANCE

Please remember to bring your insurance card(s) to your appointment to present upon arrival.

Your relationship to subscriber:	☐ Self ☐ Spouse ☐ Child				
Subscriber Name:			Subscriber ID#		
Insurance Company:			Phone:		
Employer:		Group Name:		Group#	

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ADDITIONAL DENTAL INSURANCE

Please present insurance card(s) to receptionist upon arrival

Your relationship to subscriber:	☐ Self ☐ Spouse ☐ Child				
Subscriber Name:		Subscriber ID#			
Insurance Company:		Phone:			
Employer:		Group Name:		Group#	

MEDICAL INSURANCE

Please present insurance card(s) to receptionist upon arrival

Your relationship to subscriber:	☐ Self ☐ Spouse ☐ Child				
Subscriber Name:		Subscriber ID#			
Insurance Company:		Phone:			
Employer:		Group Name:		Group#	

FINANCIAL INFORMATION

Please let us know who will be financially responsible for your treatment.

Person responsible for account:	☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other:				
Please fill out the following information for the financially responsible party:					
IF YOU ARE THE RESPONSIBLE PARTY, DO NOT FILL OUT THIS SECTION.					
Birthdate:		Social Security Number:			
Address:					
City:		State:		Zip:	
Home Phone :		Mobile Phone:			
Email:					

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MEDICAL HISTORY

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GENERAL INFORMATION

Last Name:		First Name:	
Birthdate (mm/dd/yyyy):		Gender:	☐ Male ☐ Female ☐ Other
Preferred Pronoun:	☐ Mr ☐ Mrs ☐ Ms ☐ Other	Height:	Weight:

Name of medical doctor:	
Date of last medical exam:	

Any changes in your general health in the past year? If so, please describe:
Have you ever had a serious illness? If so, please describe:
Have you been hospitalized or had surgery in the past 5 years? If so, please describe:

DO YOU HAVE OR HAVE YOU EVER HAD *(PLEASE CHECK ALL THAT APPLY)*

Cardiovascular

- ☐ Heart Attack/ Coronary Artery Disease
- ☐ Chest pain
- ☐ Irregular Heart Rate *(Atrial Fibrillation, Arrhythmia, Palpitations, Flutter)*
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Surgery (Bypass or Stent)
- ☐ Heart Valve Replacement
- ☐ Pacemaker
- ☐ Other Heart Trouble Not Listed

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Post Nasal Drip/Chronic Cough
- ☐ Sinus Problems
- ☐ Shortness of Breath

Hematology/Immune

- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Bruise or Bleed Easily
- ☐ Blood Thinner
- ☐ HIV/AIDS *(If so please know your most recent CD4 and Viral Load count)*
- ☐ Disease or Medication that may depress your immune system
- ☐ Autoimmune Disorder or Immunomodulated Disease
- ☐ History of Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Organ Transplant

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DO YOU HAVE OR HAVE YOU EVER HAD *(PLEASE CHECK ALL THAT APPLY)*

Neurologic/Psychologic

- ☐ Seizure or Epilepsy
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic Pain
- ☐ Pain Management
- ☐ History of Addiction or Substance Abuse
- ☐ Psychiatric Illness

Endocrine

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Take Insulin
- ☐ Hypothyroidism
- ☐ Other Thyroid Disorder

Skeletal/Bone/Muscular

- ☐ Arthritis / Osteoarthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Joint Replacement
- ☐ Have taken medications to prevent osteoporosis / Loss of bone density

Other Systems

- ☐ Kidney Disease
- ☐ Liver Disease (Jaundice, Hepatitis, Other)
- ☐ Acid Reflux/GERD
- ☐ Other GI disease
- ☐ Glaucoma
- ☐ Snoring or Sleep Apnea

Medical Condition(s) Not Listed

- ☐ _____
- ☐ _____
- ☐ _____

ALLERGIES, INTOLERANCES AND AVOIDANCES

Please be prepared with a list of all your allergies at the time of your appointment.

Do you have allergies to any of the following?

- ☐ Local Anesthetics (Novacaine, Lidocaine, etc.)
- ☐ Penicillin or Penicillin Family Antibiotics (Amoxicillin, Cephalosporins)
- ☐ Other Antibiotics _____
- ☐ Aspirin ☐ Ibuprofen
- ☐ Codeine ☐ Other Narcotics
- ☐ Latex ☐ Sulfa Drugs
- ☐ Soy ☐ Eggs
- ☐ Other Food Product Allergy _____
- ☐ Chemical Allergy _____
- ☐ Nickel
- ☐ Other Metal Allergy (Jewelry, etc.) _____
- ☐ Have you ever been advised to avoid taking a medication not listed?
- ☐ _____
- ☐ Do you have an allergy that is not listed? _____

Are you taking any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants or Blood Thinners
- ☐ Aspirin or Ibuprofen
- ☐ Steroids
- ☐ Tranquilizers, Sleeping Aids, Anti-Depressants
- ☐ Narcotics
- ☐ Diet Pills / Supplements
- ☐ Bone Density Medications such as Bisphosphonates *(Reclast, Foasamax, Actonel, Boniva, Aredia, Zometa, Prolia, etc.)*
- ☐ Insulin
- ☐ Oral Anti-Diabetic Drugs
- ☐ High Blood Pressure Medications
- ☐ Other Heart Drugs

MEDICATIONS

Please list ALL Medications you are taking, including diet pills, birth control, over the counter medications and holistic/herbal remedies:
We recommend that you use bottles to copy the names of your medications accurately and with correct spelling as this will help to keep you safe.

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SURGERIES

Please list all surgeries that you have had below:

ADDITIONAL INFORMATION

Do you ever smoke?	☐ Yes ☐ No	If so how many packs per day:		and for how many years:	
Do you chew tobacco?	☐ Yes ☐ No				
Do you have a history of chemical dependency or addiction?	☐ Yes ☐ No				
Do you have a history of alcohol dependency?	☐ Yes ☐ No				
Have you had any serious problems with previous dental treatment?	☐ Yes ☐ No				
If so, please explain:					
Do you have any clicking or popping of the jaw joint or difficulty opening the mouth?	☐ Yes ☐ No				
Do you clench or grind your teeth?	☐ Yes ☐ No				
Have you or an immediate family member ever had an issue with anesthesia?	☐ Yes ☐ No				
Do you have any problems, disease or conditions not listed above that you think the doctor should know about?					
If so, please provide details:					
Is there anything you would like to talk to the doctor about privately?	☐ Yes ☐ No				

FEMALE PATIENTS ONLY

Please provide the date of your last menstrual period?			
Are you pregnant or is there any chance you might be pregnant?	☐ Yes ☐ No	If so, when is your expected delivery date?	
Are you nursing? ☐ Yes ☐ No		Are you using oral contraceptives/birth control? ☐ Yes ☐ No	

If so it is important you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use additional forms of birth control for one full cycle of birth control pills after a course of antibiotics or other medications. Please consult with your physician for more information if this pertains to you.

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care.
I have read and understand the above information and have had my questions answered.

Patient Name:		Patient's Signature:	
Date:			