



Derrick D. Flint, DDS, MD

A Board Certified Oral & Maxillofacial Surgeon

(512) 838-3118 www.flintoms.com 5301 Davis Ln, Suite 102, Austin, TX 78749

## Patient Registration

### Responsible Party (If different from patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Init: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's Licence: \_\_\_\_\_

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Init: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Widowed

Employment Status:  Full Time  Part Time  Retired  Student

Person to contact in case of an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Who may we thank for referring you to our office: \_\_\_\_\_

### Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insured Birthdate: \_\_\_\_\_ Insured SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Member ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

# 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 \_\_\_\_\_  
Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_
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

- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers)? ..... Y N
- J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. 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

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

- A. Local Anesthesia (Novocain, etc.)? ..... Y N
- B. Penicillin or other antibiotics? ..... Y N
- C. Sedatives, Barbiturates? ..... Y N
- D. Aspirin or Ibuprofen? ..... Y N
- E. Codeine or other pain killers? ..... Y N
- F. Latex or Rubber Products? ..... Y N
- G. Other allergies or reactions? Please, list ..... Y N

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 is there any chance you might be Pregnant? ..... Y N

B. Are you nursing? ..... Y N

C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

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

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 Health History with my doctor.

Date \_\_\_\_\_ Signature of Person Completing Health History \_\_\_\_\_ Doctor's Initials \_\_\_\_\_

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Medical Update: I have ready my Health History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

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



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PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone \_\_\_\_\_

- O.K. to leave message with detailed information
Leave message with call-back number only

Written Communication

- O.K. to mail to my home address
O.K. to mail to my work/office address
O.K. to fax to number indicated
O.K. to text to cell phone

Work Telephone \_\_\_\_\_

- O.K. to leave message with detailed information
Leave message with call-back number only

Other (Fax/Cell, etc.) \_\_\_\_\_

I allow you to give my clinical information to or answer questions from (check all that apply):

- Spouse
Parent
Child
Other (specify): \_\_\_\_\_
None

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth date



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## **Acknowledgement of Patient Responsibility**

Fees for treatment are due at the time of service. I understand that my insurance will be billed as a courtesy, and it is my responsibility to know and understand the exclusions and limitations of my dental insurance policy. Should my insurance change, I understand that it is my responsibility to inform Flint OMS with this information.

I understand that fees given are only an estimate and agree to pay all fees (co-pays and deductibles) in full, as well as any portion not covered by my insurance company for ANY reason.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Print Name (Responsible party)

\_\_\_\_\_  
Signature (Responsible party)

\_\_\_\_\_  
Date