Oral Surgery Associates
Center for Dental Implants

FOND DU LAC 920-923-0111
WEST BEND 262-335-2282

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name _____ (Last / First / MI)
Birth Date _____ Age _____
Address _____ (City / State / Zip)
Social Security Number _____
Driver's License Number _____
Home phone _____ Cell phone _____
Email Address _____

☐ Single ☐ Married ☐ Long-Term Partner
☐ Separated ☐ Widowed ☐ Divorced

Name of Spouse/Partner _____
Spouse/Partner's Birth Date _____
If a child, parent's name _____
Referred by _____
Who will pay this account _____
Purpose of visit _____

EMPLOYMENT

Employer _____
Address _____
Phone _____
Present position _____
How long held _____
Spouse/partner employer _____
Present position _____
How long held _____

INSURANCE

Dental (primary) _____
Policy # _____
(secondary) _____
Policy # _____
Medical (primary) _____
Policy # _____
(secondary) _____
Policy # _____

MEDICAL

Physician _____
Address _____ (City / State / Zip)
Phone _____
Date of last medical examination _____

Do you have or have you ever had:	Yes	No
Anemia		
Diabetes		
Hepatitis		
Allergies		
to penicillin		
to local anesthetic		
Abnormal heart condition		
Abnormal bleeding from a cut		
Rheumatic fever		
Heart murmur		

Are you taking any medication _____
If yes, what _____
Other physical conditions we should be aware of _____

Are you or have you ever taken any osteoporosis medications? _____
If yes, what _____

Signature _____ Date _____

FOR OFFICE USE ONLY

Date	Service Rendered	Charge	Credit	Balance