



WESTERN PENNSYLVANIA
ORAL & MAXILLOFACIAL SURGERY PC

ONLINE REGISTRATION FORM

Marital Status

Name _____ Male / Female S M W D SEP Birth Date _____

Address _____ Email _____

Phone _____ Secondary Phone _____

Employed (Where) _____ Student _____

Dental Insurance _____ Medical Insurance _____

Name of Insurance Holder _____ SS# _____ DOB _____

Employer of insured Holder _____

Dentist _____ Physician _____

Drugstore _____ Location _____ Phone _____

Please Circle Correct Answer:

1. Yes No Are you now or have you been under the care of a physician during the past two years?
Reason _____
Doctor _____ Phone _____

Please list all Medications you are now taking in any form of Vitamins and Supplements
(Pills, Liquids, Patches, Injections)
(Please include any bisphosphonates or sexual enhancement drugs)

2. Yes No Are you allergic to any medication, latex products or adhesive tape?
Describe _____

3. Yes No Do you have any history of prolonged bleeding or excessive bleeding following surgery?
Describe _____

4. Yes No Do you have any artificial joint or valve replacements including placement of heart stents?
Describe _____

5. Yes No Do you drink alcoholic beverages? How much? _____

6. Yes No Do you take aspirin? How much? _____

8. Yes No Are you pregnant?

7. Yes No Do you use tobacco? How much? _____

9. Yes No Do you wear contact lenses?

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

- | | | | |
|------------|---|------------|-------------------------|
| 10. Yes No | Rheumatic Fever of Rheumatic Heart Disease | 20. Yes No | Kidney Disease |
| 11. Yes No | Heart Murmur / Mitral Valve Prolapse | 21. Yes No | Lung Disease |
| 12. Yes No | Heart Disease- Congenital or Valvular | 22. Yes No | Tuberculosis |
| 13. Yes No | High Blood Pressure | 23. Yes No | Jaundice or Hepatitis |
| 14. Yes No | Diabetes | 24. Yes No | Prolonged Cough |
| 15. Yes No | Asthma | 25. Yes No | Venereal Disease |
| 16. Yes No | Thyroid Disease | 26. Yes No | Anemia |
| 17. Yes No | Liver Disease | 27. Yes No | Contact with Aids Virus |
| 18. Yes No | Cancer : _____ | 28. Yes No | Use of Street Drugs |
| 19. Yes No | Do you have any other illness?
Please explain: _____ | 29. Yes No | Use of Methadone |