DIXIE ORAL MAXILLOFACIAL & IMPLANT SURGERY

Wayne H. Dudley, D.D.S. Matthew Mizukawa, D.M.D.

BOARD CERTIFIED, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

St. George Office:
1308 East 900 South, Ste. A
St. George, UT 84790 435-673-1554

Cedar City Office:
415 N. Main, Ste. 204
Cedar City, UT 84721 435-867-1474

PATIENT REGISTRATION

Date:________________________ Home phone: ____________________ Cell phone:_________________

Best number to reach you about appointments and or leave a message regarding your appointments? : Home, Cell

Phone number for texting________________ Phone carrier : Verizon, Sprint, T-Mobile, At&T, Other___________

Patient: ____ Marital Status:______________

Last Name First Name Middle Initial

E-mail Address: ____

Mailing Address: ___________________________________ City: ________________ State: _____ Zip Code:_________

Sex: M _____ F ____ Age: __________ Birth Date: __________________S.S. # ______________________________

Employer: ____ Employer Phone: ___________________

Spouse Name: ________________ Spouse's Employer: ________________ Employer Phone: ____________________

Closest relative not living with you: ____________________________ Phone: ______________________________

Whom may we thank for referring you?____

Who is your General Dentist?____

MEDICAL HISTORY

Physician's Name: ____ Date of Last Physical: _______________________

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Heart Problems	___	___	Sinus Problems	___	___	Nervous Problems
___	___	Artificial Heart Valves	___	___	Stroke	___	___	Psychiatric Care
___	___	Artificial Joints	___	___	Blood disease	___	___	Chemical Dependency
___	___	Rheumatic Fever, Murmur	___	___	Bleeding Disorder	___	___	Back Problems
___	___	High Blood Pressure	___	___	Hepatitis, Jaundice	___	___	Arthritis
___	___	Shortness of Breath			or Liver Disease	___	___	Venereal Disease
___	___	Circulatory Problems	___	___	Kidney Disease	___	___	AIDS / Other Immuno-
___	___	Lung Disorder	___	___	Chronic Diarrhea			suppressive Disorder
___	___	Asthma	___	___	Ulcer	___	___	Allergies to Anesthetic
___	___	Thyroid Disease	___	___	Diabetes	___	___	Allergies to Medicines
___	___	Epilepsy	___	___	Special Diet			or Drugs
___	___	Headaches	___	___	Recent Weight Loss	___	___	General Allergies
___	___	Swollen Neck Glands	___	___	Cancer	___	___	Sleep Apnea (use
___	___	Radiation Treatment						CPAP)

Do you have any drug allergies or have you ever had any adverse reaction to any medication? ________ If so, please explain

____

Have you ever responded adversely to medical or dental treatment? _____________________________________

Are you taking any medications at this time? _____ If so, what? ____

____

____

Have you taken any oral or IV medications called Bisphosphonates? (i.e. Zometa, Aredia, Fosamax, Actonel, Boniva) ___ Yes ___ No

Are you under the care of a physician? ___ Yes ___ No For what condition? _______________________________

Do you use tobacco? ___Yes ___ No If yes: do you ___ *Smoke(cigarettes) or use Smokeless (*Chewing tobacco) Frequency: ____

Female Patients: Do you suspect that you are pregnant? _____Yes ___ No Trimester ____ Are you nursing? ____Yes ____ No

Is there anything else we should know about your medical history including the use of herbs or health supplements?

____

PERSON RESPONSIBLE FOR PAYMENT

If you are a **parent bringing a minor**, the signer of the registration and financial agreement will be listed as the responsible party.
(If you are **18 years of age** or older **you** are the person responsible and signing all forms.)

Name ____ Circle one (Self, Parent, Legal Guardian)

P.O. Box /
Street Address: ____ Home Phone: ____________________

____ Work Phone: _____________________

Employer: ____ Cellular / Daytime Phone: ___________

Responsible Party's Driver's License Number: ________________________ S.S. #: _________________________

Date of Birth _____________________

INSURANCE INFORMATION

Medical / Dental Insurance is a contract between the insured and the insurance carrier. The patient is responsible to our office for the total fees charged for services rendered. We are happy to bill your insurance company as a service to you if you supply us with the necessary information.

Primary Medical / Dental (Circle One)

Insurance Company: ___________________________

Name of Policy Holder: ___________________________

Date of Birth of Policy Holder: _______________________

Employer: ______________________________________

Member ID.#:_____________________________________

Relationship to Patient______________________________

Insur Co Address: _________________________________

____

Phone #: ____

Secondary Medical / Dental (Circle One)

Insurance Company_________________________

Name of Policy Holder: __________________________

Date of Birth of Policy Holder:_____________________

Employer: __________________________________

Member ID.#:__________________________________

Relationship to Patient___________________________

Insur Co. Address.: ______________________________

____

Phone #:____________________________________

The information on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omission that I may have made in completing the form.

I have read and / or been furnished with a copy of the "Notice of Privacy Practices" for Dixie Oral, Maxillofacial and Implant Surgery.

I agree to pay in full all fees that are incurred during my dental treatment or treatment of the above patient. I also understand that I am responsible for any balance not paid by my insurance company.

_______________________________ Patient's Signature | ________ Date | _______________________________ Parent / Guardian's Signature | _________ Date

(Updated April 2019)