



Reading Oral Surgery Group, LTD
Specializing in Oral and Maxillofacial Surgery

Welcome to our practice!

The Doctors and Staff at Reading Oral Surgery welcome you and would like your initial visit to our office to be a good one. To expedite the registration process, we have enclosed copies of the three forms that we require you to complete at your initial visit:

HIPAA Privacy Information Sheet
General Registration Form
Medical History

Please complete these forms to the best of your ability and bring them with you to your first appointment.

Please remember to also bring the following:

Photo ID
Insurance Information/Insurance Cards
Prescription Medication List
X-Ray

If a referral is required by your insurance plan, you are responsible for obtaining that referral and must bring it with you to your appointment.

If the patient is under the age of 18 years old, a biological parent or legal guardian must accompany patient. Legal guardians must bring proof of guardianship.

Any patient that has a person designated as Power of Attorney, must have that person present at the time of the appointment and additionally, must submit the proper POA documentation.

Since time has been specifically reserved for you, we do have a cancellation policy that needs to be followed.

These suggestions are intended to help make your registration process go as smoothly as possible.

Thank you,

The Doctors and Staff of Reading Oral Surgery

Ronald M. Martin, D.M.D.
Paul R. Farrell, D.M.D.
Therese DiFlorio Brennan, D.M.D., M.D.





Date _____

PATIENT REGISTRATION

(IF UNDER 18 YEARS OF AGE OR COVERED UNDER PARENTS INSURANCE POLICY, PLEASE FILL OUT REVERSE SIDE OF FORM)

Patient's Name _____ (Last, First & Initial) SEX M / F Date of Birth: _____ Age _____

Patient's Address _____ Street City State Zip

Patient's Social Security # _____ () Single () Married () Widowed () Divorced

Telephone # Home _____ Cell _____ Work _____

Patient's Employer Name _____

**** PLEASE FILL OUT THE FOLLOWING INSURANCE INFORMATION ****

Do you have insurance through your employer? () Yes () No

SURGICAL:

Insurance Company _____
Group # _____
Agreement / ID # _____

DENTAL:

Insurance Company _____
Group # _____
Agreement / ID # _____

Do you have any other Insurance Coverage? () Yes () No (List Below)

This coverage is through: () SPOUSE () PARENT () OTHER _____

Their Name (Last, First & Initial) _____

Social Security #: _____ Date of Birth: _____

Place of Employment (Name & Address): _____

SURGICAL:

Insurance Company _____
Group # _____
Agreement / ID # _____

DENTAL:

Insurance Company _____
Group # _____
Agreement / ID # _____

Who may we thank for referring you to our office? _____

Family Dentist _____ Family Doctor/Physician _____

ACKNOWLEDGMENT AND AUTHORITY: I have completed this form fully and completely, and certify that I am the patient or the duly authorized agent of the patient furnishing the information requested. I also understand that if I am eligible for Medical Assistance, payment for this service will be made from Federal and State funds, and that any false claim, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I understand that, even if I have some type of insurance coverage, **I AM RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED.** I understand that if I have some type of insurance coverage, I authorize the release of any information related to my insurance claim and also authorize any group insurance benefits payable to me to be made to Reading Oral Surgery Group, Ltd. I also understand that I will be billed for any services covered by insurance if payment is not received within 45 days of the INITIAL claim. I also authorize the Reading Oral Surgery Group, Ltd. to perform a credit check through a bonded credit bureau or service if I elect a Payment Plan as a preferred method of payment. **THERE WILL BE A \$30.00 CHARGE FOR ALL RETURNED CHECKS.** THE POLICY IN THIS OFFICE IS the parent who requests treatment for the child is responsible for all fees for services rendered.

Witness _____

Signed (Patient/Parent) _____



REGISTRATION FOR MINORS OR STUDENTS

Date _____

Patient's Name _____ SEX M / F Date of Birth: _____ Age _____
(Last, First & Initial)

Patient's Address _____

Patient's Social Security # _____ Telephone # Home _____ Cell _____

Is patient a full time student? () Yes () No If yes, where _____
(Name of School) (State)

**** PLEASE FILL OUT THE FOLLOWING INSURANCE INFORMATION ****

Father: _____ Date of Birth: _____
Last First M.I.

Address: _____ Phone: _____

Soc. Sec. #: _____ Employer: _____ Phone: _____

SURGICAL:

Insurance Company _____

Group # _____

Agreement / ID # _____

DENTAL:

Insurance Company _____

Group # _____

Agreement / ID # _____

Mother: _____ Date of Birth: _____
Last First M.I.

Address: _____ Phone: _____

Soc. Sec. #: _____ Employer: _____ Phone: _____

SURGICAL:

Insurance Company _____

Group # _____

Agreement / ID # _____

DENTAL:

Insurance Company _____

Group # _____

Agreement / ID # _____

Who may we thank for referring you to our office? _____

Family Dentist _____ Family Doctor/Physician _____

ACKNOWLEDGMENT AND AUTHORITY: I have completed this form fully and completely, and certify that I am the patient or the duly authorized agent of the patient furnishing the information requested. I also understand that if I am eligible for Medical Assistance, payment for this service will be made from Federal and State funds, and that any false claim, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I understand that, even if I have some type of insurance coverage, **I AM RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED.** I understand that if I have some type of insurance coverage, I authorize the release of any information related to my insurance claim and also authorize any group insurance benefits payable to me to be made to Reading Oral Surgery Group, Ltd. I also understand that I will be billed for any services covered by insurance if payment is not received within 45 days of the INITIAL claim. I also authorize the Reading Oral Surgery Group, Ltd. to perform a credit check through a bonded credit bureau or service if I elect a Payment Plan as a preferred method of payment. **THERE WILL BE A \$30.00 CHARGE FOR ALL RETURNED CHECKS.** THE POLICY IN THIS OFFICE IS the parent who requests treatment for the child is responsible for all fees for services rendered.

Signed _____ Signed (Parent) _____
(Patient - If Not Minor)

Witness

HEALTH HISTORY

Age _____

Weight _____

Please circle any of the following conditions which have ever applied to you.

- | | | | | |
|---------------------|-----------------|-------------------|------------------------|----------------------|
| Heart attack | Stroke | Alcoholism | Liver disease | Hiatal hernia |
| Heart disease | Rheumatic fever | Anemia | Kidney disease | Contagious disease |
| High blood pressure | Asthma | Hepatitis | Lung disease | Epilepsy |
| Chest pain (angina) | Emphysema | Jaundice | Cancer | Arthritis |
| Shortness of breath | Diabetes | Artificial joints | Radiation treatment | Psychiatric problems |
| Heart murmur | Glaucoma | Artificial valves | Chemotherapy treatment | Gastric Reflux |
| Blocked Arteries | Allergies | | | |

Yes/No Do you have a family physician? If yes, physician's name _____

Yes/No Have you been under the care of a physician during the last five years?

Yes/No Have you ever been treated in an emergency room?

Yes/No Within the past 10 years, have you been admitted as a patient to a hospital?

Yes/No Are you allergic to latex, penicillin, codeine, aspirin, local anesthesia, barbiturates, pentothal, or any other drugs, any foods (i.e. soy, eggs, sulfites)

Yes/No Have you ever had heart problems? () High Blood pressure () Low pressure
 () Heart Attack () Chest Pain (angina) () Irregular Heart Beat
 () Heart Murmur () Rheumatic Fever () Other Cardiac Problems

Yes/No Do you have to take antibiotics to protect your heart, artificial joints, or for any other reason before dental work or oral surgery?

Yes/No Do you have or have you recently had a cold or respiratory problems?

Yes/No Have you ever been told you have: () Asthma (last time seen emergency room
 or Dr's office _____) () Bronchitis () Pneumonia () Cough
 () Tuberculosis () Emphysema () Sleep Apnea / Sleep Disorder

Yes/No Have you had any other illness not listed above? _____

Yes/No Have you or any family member ever had difficulty with general anesthesia?

Yes/No Have you ever taken prednisone, cortisone or other steroid medicines?

Yes/No Have you had bleeding problems following dental surgery?

Yes/No Have you used any alcohol or drugs (recreational or street) in the past 72 hours? If yes, please check: () Alcohol
 () Marijuana () Cocaine () Barbiturate () Heroin () Amphetamines () Other _____
 Undisclosed use of these drugs can be extremely dangerous if you have a general anesthetic.

Yes/No Do you have a history of chemical dependency? If yes, how long have you been in recovery? _____

Yes/No Do you smoke? How many packs per day? _____ppd

Yes/No Are you wearing dentures? Yes/No Contact lenses?

(Women) Are you pregnant? _____ How many months? _____ Are you nursing? Yes/No

'PLEASE COMPLETE REVERSE SIDE'

Yes/No Do you take any medications, herbal remedies, or supplements on a regular or occasional basis? List medications:

Yes/No Have you ever received chemotherapy for cancer? If yes, physician prescribing _____
Medication name: _____ Dosage / Frequency _____

Yes/No Are you **currently** taking Fosamax, Actonel/Boniva? If yes, physician prescribing _____
Medication name: _____ Dosage / Frequency _____

When did you start taking the medication? _____

Yes/No Have you **ever** taken Fosamax, Actonel/Boniva? If yes, physician prescribing _____
Medication name: _____ Dosage / Frequency _____

When did you start taking the medication? _____

Medical Notes: _____

To the best of my knowledge this information is correct and complete.

Signed _____ Date _____

If you completed this form for the patient what is your relationship to the patient? _____
