



3209 Fiday Road, Joliet, IL 60431  
P: 815.254.1560 • F: 815.254.1562  
www.wisdomteethjoliet.com

# REGISTRATION FORM

## PATIENT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Email \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relation: \_\_\_\_\_ Phone # \_\_\_\_\_

## REFERRAL INFORMATION

Referred by \_\_\_\_\_  
Patient's Dentist \_\_\_\_\_ Office # \_\_\_\_\_

## INSURANCE INFORMATION

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ S.S.# \_\_\_\_\_  
MEDICAL INSURANCE \_\_\_\_\_ ID # \_\_\_\_\_  
DENTAL INSURANCE \_\_\_\_\_ ID # \_\_\_\_\_

## HEALTH QUESTIONNAIRE

Have you been under the care of a physician in the past year? .....  Yes  No  
\*If yes: date of your last visit? \_\_\_\_\_ What condition are you being treated? \_\_\_\_\_

Have you been hospitalized or had any surgeries in the past five (5) years?.....  Yes  No  
\*If yes: date of your last visit? \_\_\_\_\_ What condition are you being treated? \_\_\_\_\_

Do you have a prosthetic joint/implant? .....  Yes  No  
\*If so, where \_\_\_\_\_ Any post-operative infections?.....  Yes  No  
\*Did your orthopedic surgeon say you need to pre-medicate before any dental procedure?.....  Yes  No

## SECTION FOR FEMALE PATIENTS ONLY

Are you pregnant?.....  Yes  No  
\*If yes, expected delivery date \_\_\_\_\_



**SOCIAL HABITS**

- Do you chew or smoke tobacco? .....Yes No (if yes, how much & for how long) \_\_\_\_\_
- Do you smoke cannabis/marijuana? ...Yes No (if yes, how much & for how long) \_\_\_\_\_
- Do you use edibles? .....Yes No (if yes, how much & for how long) \_\_\_\_\_
- Do you drink alcoholic beverages? ....Yes No (if yes, how much & for how long) \_\_\_\_\_
- Do you use any illicit drugs.....Yes No (if yes, how much & for how long) \_\_\_\_\_

**HAVE YOU OR DO YOU CURRENTLY HAVE**

- |   |  |
|---|--|
| 1. Rheumatic Fever?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 31. Stroke?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| 2. Damaged Heart Valves?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 32. Thyroid Trouble?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Mitral Valve Prolapse?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| 4. Heart Murmur?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | Do you use an insulin pump? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. High Blood Pressue?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 34. Low Blood Sugar?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 6. Low Blood Pressure?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 35. Kidney Trouble? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 7. Chest Pain?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | 36. Are you on dialysis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| 8. Heart Attack(s)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 37. Arthritis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| 9. Irregular Heart Beat..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 38. Joint Disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 10. Cardiac Pacemaker?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 39. Stomach Ulcers?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| 11. Heart Surgery?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | 40. HIV / AIDS?..... <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Date of Surgery _____   | 41. Immune System Issues?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 12. Swollen Ankles?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 42. Tumor or Growth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 13. Bronchitis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | Location & Date _____  |
| 14. Chronic Cough?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | 43. Radiation Therapy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| 15. Asthma?..... <input type="checkbox"/> Yes <input type="checkbox"/> No               | 44. Chemotherapy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| 16. Sinus Issues?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 45. Chronic Fatigue?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 17. Snoring?..... <input type="checkbox"/> Yes <input type="checkbox"/> No              | 46. Night Sweats?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| 18. Sleep Apnea?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 47. Glaucoma? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| 19. Difficult Breathing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 48. Mental Health Problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 20. Lung Trouble?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 49. Depression?..... <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| 21. Tuberculosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 50. Anxiety?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| 22. Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No             | 51. Malignant Hyperthermia?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 23. COPD?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 | 52. Blood Transfusion?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| 24. Bruise Easily?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | Date of Transfusion _____  |
| 25. Bleeding Tendency?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 53. Mononucleosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 26. Hepatitis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | 54. Delayed Healing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 27. Liver Disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | 55. Gall Bladder Trouble?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 28. Fainting Spells?..... <input type="checkbox"/> Yes <input type="checkbox"/> No      | 56. Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| 29. Epilepsy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No             | Other medical issues not listed? _____   |
| 30. Seizures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No             | _____  |



3209 Fiday Road, Joliet, IL 60431  
P: 815.254.1560 • F: 815.254.1562  
www.wisdomteethjoliet.com

**MEDICATION** – *Are you taking or have you ever taken...*

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates, such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista?..... Yes No

Please list any medications you are currently taking: \_\_\_\_\_

**ALLERGIES** – *Are you allergic to or have you had a reaction to...*

Local anesthetics (numbing medications)?..... Yes No

Antibiotics?..... Yes No

If yes, which antibiotics allergic to: \_\_\_\_\_

Aspirin?..... Yes No

Codeine or other narcotics?..... Yes No

Latex?..... Yes No

Please list any allergies other than drug allergies \_\_\_\_\_

By signing, I certify that I read and understand the questions above and I will not hold Dr. Babiuk or his associates responsible for any omissions or errors made during the completion of this form.

**AUTHORIZATION & FINANCIAL INFORMATION**

I authorize Dr. Babiuk and his associates to perform an oral examination and take all x-rays deemed necessary for the purpose of diagnosis and treatment planning. Several factors determine the fee for oral surgery services, including the complexity and advancement of the situation; you will be informed of any fees before treatment is started. We understand your health and/or dental insurance may not cover all of the cost of your treatment, and we make every effort to help you maximize your coverage and increase your reimbursement. Financial options will also be discussed during your initial visit. It is your responsibility to pay any deductible amount, co-insurance, patient portion or any other balance not paid by your insurance company. You will be responsible for all collections, attorneys and court fees if your account is in default.

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

