the WISDOM TOOTH DOC

3209 Fiday Road
Joliet, IL 60431
Office: 815-254-1560
Fax: 815-254-1562

1404 Aquarius Cir., Ste A
Ottawa, IL 61350
Office: 815-324-4470
Fax: 815-324-4474

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 #_____

Pharmacy_____ Address_____ Phone #_____

REFERRAL INFORMATION

Referred by_____

Patient's Dentist_____ Office #_____

INSURANCE INFORMATION

Subscriber Name:_____ DOB:_____ S.S.#_____

MEDICAL INSURANCE_____ ID #_____

DENTAL INSURANCE_____ ID #_____

HEALTH QUESTIONAIRE

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_____

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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?.....☐Yes ☐No
2. Damaged Heart Valves?.....☐Yes ☐No
3. Mitral Valve Prolapse?.....☐Yes ☐No
4. Heart Murmur?.....☐Yes ☐No
5. High Blood Pressue?.....☐Yes ☐No
6. Low Blood Pressure?.....☐Yes ☐No
7. Chest Pain?.....☐Yes ☐No
8. Heart Attack(s)?.....☐Yes ☐No
9. Irregular Heart Beat.....☐Yes ☐No
10. Cardiac Pacemaker?.....☐Yes ☐No
11. Heart Surgery?.....☐Yes ☐No
    Date of Surgery_____
12. Swollen Ankles?.....☐Yes ☐No
13. Bronchitis?.....☐Yes ☐No
14. Chronic Cough?.....☐Yes ☐No
15. Asthma?.....☐Yes ☐No
16. Sinus Issues?.....☐Yes ☐No
17. Snoring?.....☐Yes ☐No
18. Sleep Apnea?.....☐Yes ☐No
19. Difficult Breathing?.....☐Yes ☐No
20. Lung Trouble?.....☐Yes ☐No
21. Tuberculosis?.....☐Yes ☐No
22. Emphysema.....☐Yes ☐No
23. COPD?.....☐Yes ☐No
24. Bruise Easily?.....☐Yes ☐No
25. Bleeding Tendency?.....☐Yes ☐No
26. Hepatitis?.....☐Yes ☐No
27. Liver Disease?.....☐Yes ☐No
28. Fainting Spells?.....☐Yes ☐No
29. Epilepsy?.....☐Yes ☐No
30. Seizures?.....☐Yes ☐No
31. Stroke?.....☐Yes ☐No
32. Thyroid Trouble?.....☐Yes ☐No
33. Diabetes?.....☐Yes ☐No
    Do you use an insulin pump? .....☐Yes ☐No
34. Low Blood Sugar?.....☐Yes ☐No
35. Kidney Trouble? .....☐Yes ☐No
36. Are you on dialysis?.....☐Yes ☐No
37. Arthritis?.....☐Yes ☐No
38. Joint Disease?.....☐Yes ☐No
39. Stomach Ulcers?.....☐Yes ☐No
40. HIV / AIDS?.....☐Yes ☐No
41. Immune System Issues?.....☐Yes ☐No
42. Tumor or Growth?.....☐Yes ☐No
    Location & Date_____
43. Radiation Therapy?.....☐Yes ☐No
44. Chemotherapy?.....☐Yes ☐No
45. Chronic Fatigue?.....☐Yes ☐No
46. Night Sweats?.....☐Yes ☐No
47. Glaucoma? …….....☐Yes ☐No
48. Mental Health Problems?.....☐Yes ☐No
49. Depression?.....☐Yes ☐No
50. Anxiety?.....☐Yes ☐No
51. Eating Disorder?.....☐Yes ☐No
52. Malignant Hyperthermia?.....☐Yes ☐No
53. Blood Transfusion?.....☐Yes ☐No
    Date of Transfusion_____
54. Mononucleosis?.....☐Yes ☐No
55. Delayed Healing?.....☐Yes ☐No
56. Gall Bladder Trouble?.....☐Yes ☐No
57. Anemia…….. ☐Yes ☐No

Other medical issues not listed? _____

_____

_____

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www.wisdomteethjoliet.com

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

Please list any medications you are currently taking:_____

_____

_____

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

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

Antibiotics?.....☐Yes ☐No

If yes, which antibiotics allergic to:_____

Aspirin?.....☐Yes ☐No

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

Latex?.....☐Yes ☐No

Please list any other allergies_____

I authorize TheWisdomToothDoc/Dr. James Babiuk to release medical and billing information to:

Individual Name:_____Relation to Patient:_____

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 scans 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_____