GARDEN STATE
ORAL SURGERY GROUP
gardenstateos.com

REGISTRATION

Date:_____

PATIENT INFORMATION

Name:_____

Address: _____ City, State, Zip Code:_____

Phone: Home:_____ Work:_____ Cell:_____

Date of Birth:_____ Social Security Number:_____-_____-_____

Employer:_____

Address: _____ City, State, Zip Code:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____

Address: _____ City, State, Zip Code:_____

Phone: Home:_____ Work:_____ Cell:_____

Date of Birth:_____ Social Security Number:_____-_____-_____

Employer:_____

Work Address: _____ City, State, Zip Code:_____

PHYSICIANS

Dentist:_____ Primary Care Physician:_____

Chiropractor:_____ Other:_____

DENTAL INSURANCE

Primary Coverage:

Insured's Name:_____

Insurance Company Name:_____

Name of Group or Plan:_____

Policy No:_____ Group No:_____

Secondary Coverage

Insured's Name:_____

Insurance Company Name:_____

Name of Group or Plan:_____

Policy No:_____ Group No:_____

MEDICAL INSURANCE

Primary Coverage:

Insured's Name:_____

Insurance Company Name:_____

Name of Group or Plan:_____

Policy No:_____ Group No:_____

Secondary Coverage

Insured's Name:_____

Insurance Company Name:_____

Name of Group or Plan:_____

Policy No:_____ Group No:_____

How would you like to pay for today's services?

☐ Cash ☐ Check ☐ MC/VISA ☐ Care Credit

Bayonne Oral Surgery
925 Broadway
Bayonne, NJ 07002
(201) 858-1400 - bayonne@gardenstateos.com

Oral & Maxillofacial Surgery Institute
67-73 Fillmore St
Newark, NJ 07105
(973) 643-1130 - newark@gardenstateos.com

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HEALTH HISTORY

Are you in good health? ☐ Yes ☐ No

Has there been any change in your general health in the past year? ☐ Yes ☐ No

Date of your last physical exam: Date: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If so, what is the condition being treated? _____

Name and address of your physician: _____

Any serious illnesses, operations, or hospitalizations in the past? ☐ Yes ☐ No

If so, what was the illness or operation? _____

Are you taking any medications? ☐ Yes ☐ No

If so, what are they? _____

Are you taking birth control pills? ☐ Yes ☐ No

Are you allergic to any medications?

☐ Penicillin ☐ Local Anesthetics ☐ Codeine ☐ Sulfa ☐ Aspirin ☐ Latex ☐ Other: _____

Do you have or have you had any of the following diseases? Check all that apply:

Cardiovascular Disease
- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Heart Attack Pacemaker
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Rheumatic Heart Disease

Neurological Disease
- ☐ Epilepsy
- ☐ Seizures
- ☐ Stroke
- ☐ Mental Health
- ☐ Alcohol – How much? _____
- ☐ Recreational Drugs – How much? _____

Respiratory Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Smoke/Tobacco – Packs per day? _____

Rheumatology
- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Gout

Hematology/Oncology
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment

Renal Disease
- ☐ Kidney Disease
- ☐ Renal Failure

Gastrointestinal Disease
- ☐ GI Bleeding
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Stomach Ulcers

Infectious Disease
- ☐ AIDS/HIV Infection
- ☐ TB
- ☐ Venereal Disease

Endocrine Disease
- ☐ Diabetes
- ☐ Thyroid Disease

Are you pregnant? ☐ Yes ☐ No If so, how many months? _____

When did you last eat or drink? _____

Are there any other important facts we should know about you? ☐ Yes ☐ No

What are they? _____

I certify that I have read, and I understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental/Medical care to third-party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group Insurance benefits otherwise payable to me. I understand that my Dental/Medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to pay all reasonable attorney fees and collection costs in the event of default of this payment agreement.

_____ _____

Signature Date

Medical History Reviewed by doctor: _____

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