O2 Dentistry & Associates

9450 Scranton Rd. #109,
San Diego, CA 92121
(858) 457-8514

PATIENT REGISTRATION

PATIENT INFORMATION

Name_____ Date of Birth:_____ Age: _____ Gender: _____Date:_____
Address:_____ City:_____ State:_____ ZIP:_____ Home phone:_____
Occupation:_____ SSN:_____ Email:_____Cell phone:_____
Employer: _____ Address: _____ Pharmacy: _____

Primary physician:_____ Phone:_____
Specialist physician:_____ Phone:_____

Medical insurance:_____ Group:_____ Member ID:_____ Active date: _____
Primary Dental Insurance:_____ Group:_____ Member ID: _____Active date: _____
Subscriber: _____ Date of Birth: _____
Secondary Dental Insurance:_____ Group:_____ Member ID: _____Active date: _____

GUARDIAN INFORMATION

Name_____ Date of Birth:_____ Age: _____ Gender: _____Date:_____
Address:_____ City:_____ State:_____ ZIP:_____ Home phone:_____
Occupation:_____ SSN:_____ Email:_____Cell phone:_____

EMERGENCY CONTACT INFORMATION

Name_____ Date of Birth:_____
Address:_____ City:_____ State:_____ ZIP:_____
Home phone number:_____ Cell number:_____ Email:_____

AKNOWLEDGEMENT

I certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Osmolinski (O2 Dentistry) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsibly party signature_____ Relationship_____ Date_____

DENTAL HISTORY

Reason for today's visit: _____ Who may we thank for referring you: _____
Former dentist:_____ City:_____ State:_____
Date of the last dental visit:_____ Reason:_____
Please elaborate on any past unpleasant experience in a dental office:_____

Do you suffer from any of the following:

bad breath	Y	N	sensitivity to cold	Y	N
blisters on lips or mouth	Y	N	sensitivity to hot	Y	N
sores or growths in mouth	Y	N	bleeding gums	Y	N
mouth breathing	Y	N	swollen or tender gums	Y	N
clicking or popping of the jaw	Y	N	cigarette, pipe, cigar smoking	Y	N
missing teeth	Y	N	chewing tobacco	Y	N
pain around the ear	Y	N	dry mouth	Y	N
sensitivity when biting down	Y	N	food collection between teeth	Y	N
grinding or clenching teeth	Y	N	sensitivity to sweet	Y	N
loose teeth or broken fillings	Y	N	burning sensation on the tongue	Y	N
pain with brushing	Y	N	lip or cheek biting	Y	N

Have you ever had:

periodontal therapy	Y	N	oral surgery	Y	N
orthodontic therapy	Y	N	dental treatment under anesthesia	Y	N

GENERAL MEDICAL HISTORY

Are you in good health?	Y N
Any change in your health within past 1 year?	Y N
Date of the last physical examination	_____
What is your weight	_____
What is your height	_____
Have you been seriously ill in the past 5 years?	Y N
Did you undergo any surgery in the past 5 years	Y N
Have you been hospitalized in the past 5 years?	Y N

MEDICATIONS - SUPPLEMENTS - HERBAL REMEDIES

_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

CARDIOVASCULAR SYSTEM

congenital heart defects	Y N
damaged/ artificial heart valves	Y N
rheumatic heart disease	Y N
history of heart attack	Y N
angina, coronary insufficiency	Y N
blood pressure abnormalities	Y N
arteriosclerosis	Y N
high cholesterol	Y N
history of stroke	Y N
chest pain upon exertion	Y N
short of breath after exercise	Y N
swollen ankles	Y N
cardiac pacemaker	Y N

RESPIRATORY SYSTEM

difficulty breathing or sinus trouble	Y N
asthma or hay fever	Y N
respiratory problems or emphysema	Y N
history of tuberculosis	Y N
persistent cough or cough with blood	Y N
obstructive sleep apnea	Y N
pulmonary embolism	Y N
swollen lymph glands	Y N
recent respiratory infection	Y N

HEPATO-GASTRO-INTESTINAL SYSTEM

diabetes	Y N
hepatitis or liver diseases	Y N
weight loss/ eating disorder	Y N
episodes of nausea or vomiting	Y N
stomach ulcer or hyperacidity	Y N
reflux disease/ gag reflex	Y N
pancreatitis/ gallbladder disease	Y N
diarrhea/ bowel obstruction	Y N
Crohn's disease/ Irritable Bowel Syndrome	Y N
hiatal hernia	Y N

NEURO-MUSCULOSKELETAL SYSTEM

recurrent headaches/ migraines	Y N
fainting/ seizures/ epilepsy	Y N
emotional/ mental health problems	Y N
serious head injury/ trauma	Y N
paresthesia/ stroke	Y N
developmentally delayed	Y N
psychiatric disorder	Y N
cerebral palsy/ paralysis	Y N
multiple sclerosis	Y N
osteoporosis/ osteopenia	Y N
problems with cervical spine	Y N
arthritis/ painful swollen joints	Y N
degenerative joint disease	Y N
artificial joints/ joint replacement	Y N
back problems	Y N

RENAL-ENDOCRINE SYSTEM

thyroid problems	Y N
kidney problems/ dialysis	Y N
adreno-cortical insufficiency	Y N
pituitary disorder	Y N
steroid use	Y N
hormonal disturbances	Y N

OTHER SYSTEMS

anemia	Y N
abnormal bleeding	Y N
history of blood transfusions	Y N
cancer/ history of tumor growth	Y N
problems with auto-immune system	Y N
eye disease/ glaucoma/ contact lenses	Y N
hoarseness	Y N
hearing impairment	Y N
sexually transmitted disease	Y N
HIV infection/ AIDS	Y N
any disease not listed above	Y N

SOCIAL HISTORY

smoking or chewing tobacco	Y N	how much	_____ ppd _____ years
alcohol	Y N	how much	_____ drinks _____ week
illicit/ street drugs	Y N	specify	_____
any disability	Y N	immunization up to date	Y N
history of treatment with BIPHOSPHONATES	Y N	have you ever taken Phen-Fen or Reduxa	Y N

WOMEN

Are you **pregnant** or trying to get pregnant	Y N	If pregnant, how many weeks	_____
Any problems with the menstruation periods	Y N	Are you nursing	Y N

CHILDREN

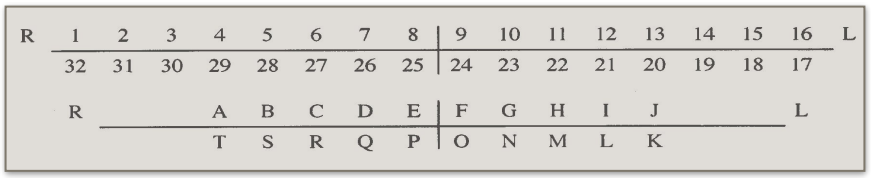
Were there any complications during the pregnancy?	Y N	How was your child delivered	VAGINAL C-SECTION
Your child was born at: _____ weeks		If C-SECTION, reason:	_____
Complications during the newborn period:	_____		

ANESTHESIA HISTORY

Have you ever had administered any type of anesthesia?	Y	N
Specify _____		
Have you ever had any **complications with anesthesia**?	Y	N
Specify _____		
Had anybody from your family have any problems with anesthesia?	Y	N
Specify _____		
Do you have a family history of malignant hyperthermia?	Y	N
Do you have history of prolonged nausea and vomiting after anesthesia?	Y	N
Do you have a history of difficult airway?	Y	N
Do you have problems with your temporomandibular joint?	Y	N
Do you have limited mouth opening?	Y	N
Did you ever had any operation or radiation in your maxillofacial region?	Y	N
Did you undergo any ENT procedures before?	Y	N
Have you ever had tracheostomy procedure done?	Y	N
Do you have a history of difficult IV start?	Y	N
Have you ever had any abnormal reaction to medications?	Y	N

I certify that I have provided an accurate and complete personal and medical history and I have not knowingly omitted any information. I understand that providing incomplete or inaccurate information may negatively influence the treatment and treatment results. Should there be any change in either my health status or any other information I have provided, I will advise my dental anesthesiologist. I authorize Dr. Osmolinski and Associates to request to have diagnostic procedures performed as may be required to determine the necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.

_____	_____	_____
Patient name	Patient signature	Date
_____	_____	_____
Doctor name	Doctor signature	Date



Tooth	Clinical Findings	Radiographic Findings	Treatment Options	Seq.	Time