

# Piney Point Oral and Maxillofacial Surgery

Thomas M. Weil, DDS

Steve L. Koo, DDS

2450 Fondren Suite 320  
Houston, Texas 77063  
(713) 783-5560  
www.PineyPointOMS.com

**Step 1:** Please complete as many form fields as possible.  
**Step 2:** Press the "Print" button to make a copy for your own future reference.  
**Step 3:** Press the "Submit" button to securely send the form to our office.

## NEW PATIENT REGISTRATION

Date: \_\_\_\_\_

### 1 About You

Mr.  Mrs.  Ms.  Dr.

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Sex:  Male  Female Status:  Single  Married  Minor  Widowed  Divorced

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Physician: \_\_\_\_\_

Preferred Contact Method:  Home Phone  Cell Phone  Work Phone  Email

Student:  No  Full Time  Part Time School Name: \_\_\_\_\_

Person to contact for Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is this visit related to an accident?  Yes  No If yes, date of accident: \_\_\_\_\_

Time of accident: \_\_\_\_\_ Type of accident:  Work-related  Automobile  Other (list): \_\_\_\_\_

How did you learn about our practice? (provide name): \_\_\_\_\_

### 2 Responsible Party Information (Complete if you are the parent or guardian of the patient)

Mr.  Mrs.  Ms.  Dr.

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

Preferred Contact Method:  Home Phone  Cell Phone  Work Phone  Email


Student:  No  Full Time  Part Time School Name: \_\_\_\_\_

Are you?  FT  PT If none, are you?  Retired  Disabled

3

### Insurance Information

#### PRIMARY DENTAL INSURANCE

Relation: \_\_\_\_\_  **Must select relation first**

Employer: \_\_\_\_\_

Bus. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
FIRST MI LAST

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_


Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Social Security #: \_\_\_\_\_

#### SECONDARY DENTAL INSURANCE

Relation: \_\_\_\_\_  **Must select relation first**

Employer: \_\_\_\_\_

Bus. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
FIRST MI LAST

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_


Group # (Plan, Local, or Policy #): \_\_\_\_\_

Social Security #: \_\_\_\_\_

4

### Insurance Information

#### PRIMARY MEDICAL INSURANCE

Relation: \_\_\_\_\_  **Must select relation first**

Employer: \_\_\_\_\_

Bus. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
FIRST MI LAST

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_


Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Social Security #: \_\_\_\_\_

#### SECONDARY MEDICAL INSURANCE

Relation: \_\_\_\_\_  **Must select relation first**

Employer: \_\_\_\_\_

Bus. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
FIRST MI LAST

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Social Security #: \_\_\_\_\_

### 5 General Health

Have you been a patient in a hospital in the past two years? If so, for what were you hospitalized?  No  Yes

Are you now, or have you been, under the care of a physician (including a psychiatrist) during the past two years? If so, please describe below what you were treated for?  No  Yes

Do you wear contact lenses?  No  Yes

Are you now under a physician's care for a particular problem?  No  Yes

Have you ever had any illnesses, operations or hospitalization?  No  Yes

If so, describe: \_\_\_\_\_

Please briefly state your reason for today's visit: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

### 6 Health History

**Have you ever had any of the following diseases or medical conditions or procedures?:**

- |   |  |
|---|--|
| <input type="checkbox"/> Rheumatic Fever or Rheumatic Heart Disease   | <input type="checkbox"/> Thyroid Disease (Goiter)  |
| <input type="checkbox"/> Congestive Heart Disease   | <input type="checkbox"/> Arthritis   |
| <input type="checkbox"/> Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker) | <input type="checkbox"/> Stomach Ulcers  |
| <input type="checkbox"/> Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)                                   | <input type="checkbox"/> Glaucoma  |
| <input type="checkbox"/> Seizures, Convulsions, Epilepsy, Fainting or Dizziness   | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion  | <input type="checkbox"/> Radiation (X-ray) treatment for Cancer  |
| <input type="checkbox"/> AIDS (Acquired Immune Deficiency Syndrome)   | <input type="checkbox"/> Blood disease   |
| <input type="checkbox"/> Liver Disease (Jaundice, Hepatitis)  | <input type="checkbox"/> Syphilis or venereal disease  |
| <input type="checkbox"/> Kidney or bladder trouble  | <input type="checkbox"/> Any disease, drug or transplant operation that has depressed your immune system |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Nervous disorders   |
|   | <input type="checkbox"/> Obstructive sleep apnea   |

#### MEDICATION & ALLERGIES:

List medicines, or drugs, you have taken during the past year and for what conditions: (include mg doses and frequency of use)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you taken cortisone or other hormone medication? If so, please list: \_\_\_\_\_  No  Yes

Have you had any surgical procedures in the past? Describe below: \_\_\_\_\_  No  Yes

If surgery was performed, name the surgeon: \_\_\_\_\_

Do you have prosthetic implants placed anywhere in your body: (heart valve, hip, knee, etc.) \_\_\_\_\_  No  Yes

Have you had any reactions to sulfites, hay fever or any other allergies? If so, please describe: \_\_\_\_\_  No  Yes

\_\_\_\_\_

When you cut yourself, or have a tooth extracted, do you bleed so much that you have to see a doctor to have it stopped?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever had a reaction during, or following, dental treatment or oral surgery?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you allergic to or have you had an adverse reaction to Aspirin, sulfa, or penicillin?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you allergic to or have you had an adverse reaction to Codeine or other pain killers?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you faint easily?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you get short of breath easily?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you gained, or lost, more than fifteen pounds recently?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you smoke or chew Tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes How much smoke or tobacco you use per day?	
Do you have any sores or growths in your mouth?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever had any serious injuries to your face or jaws? Describe: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you had temporomandibular joint disorder or dysfunction? ("TMJ")?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes

### 7 For Women Only

This section is for women only, men continue below. Women, continue below when you have completed this section.

Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wish to have a pregnancy test?	<input type="checkbox"/> No <input type="checkbox"/> Yes

### 8 Print and Submit

Thank you for filling out our secure online Patient Registration Form. On your visit to our office, we will have your completed form available for your signature. After you have answered the questions above to your satisfaction, please make sure to print a copy for your future reference and press the Submit button to securely send us your information. The security and privacy of your personal data is one of our primary concerns and we have taken every precaution to protect it.

**PRINT**

**SUBMIT**

### 9 Consent for Services

This section will be filled out and signed when you come to the office.

#### Lifetime Authorization Form for Oral/Maxillofacial and Cosmetic Surgery Services

I authorize treatment of the person above and agree to pay all fees and charges for such treatment to this practice's Patient Financial Agreement. I authorize the release of any medical information to any insurance or Medicare insurer that is necessary to process any insurance claim and to request payment of benefits, whether to myself or to this practice. I hereby assign payment of insurance benefits for services rendered by this practice, directly to the practice.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Responsible Party's Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

*Office use only:*

**Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Chart:** \_\_\_\_\_