

Archstone Oral & Facial Surgery — Patient Registration

Alfredo A. Dela Rosa, DDS, MD · 6063 Mission Street, Daly City, CA 94014 · (415) 963-4121 · Fax (415) 963-4171

Please print clearly. You can also register online at archstoneoralsurgery.com → Patient Information → First Visit → Patient Registration.

1 · Demographic Information

Patient information

Prefix	☐ Mr.	☐ Mrs.	☐ Ms.	☐ Dr.
Sex	☐ Male	☐ Female		
First name	M.I.		Last name	
Birth date	Age	Social Security Number		
Email address	Driver's license number			
Street address	Apt.			
City	State	Zip		
Home phone	Cell phone			
Have you ever been a patient of our practice?	☐ Yes	☐ No		
Has a family member ever been a patient of our practice?	☐ Yes	☐ No		
Referred by	Dentist			
Orthodontist	Medical doctor			
Preferred pharmacy	Pharmacy phone			
Nearest relative not living with you	Relative phone			
Employer / business name	Business phone			
Personal payment type	☐ Cash	☐ Check	☐ Credit Card	

In case of emergency

Emergency contact full name	Phone	Relation to patient
-----------------------------	-------	---------------------

Who will be responsible for your account?

Responsible party	☐ Self	☐ Spouse	☐ Father	☐ Mother	☐ Other
If other, describe					
If someone other than yourself, please complete:					
First name	Last name				
Birth date	Age	Social Security Number			
Home phone	Cell phone	Email			
Driver's license number	Employer / business name				

Street address	Apt.	City / State / Zip
Business phone		

Spouse or other guarantor information (if different from above)

First name	Last name	
Relation	Home phone	Birth date
Social Security Number	Employer / business name	
Street address	Apt.	City / State / Zip
Business phone		

2 · Insurance Information

Marital status	☐ Married	☐ Divorced	☐ Widow	☐ Single	☐ Legally Separated
Employed	☐ Full Time	☐ Part Time	☐ Retired	☐ Not	
Do you belong to a PPO or HMO?	☐ Yes	☐ No			
Are you a student?	☐ Full Time	☐ Part Time	☐ Not a student		

Primary dental insurance company

Employer / business name	Business phone	
Employer address (street, city, state, zip)		
Plan name	Insurance company name	
Policy I.D. number	Group name / number	Ins. co. phone
Insurance company address (street, city, state, zip)		
Insured party name	Relation	Birth date
Insured party sex	☐ Male	☐ Female
Insured party Social Security Number	Insured party phone	
Insured party address (street, city, state, zip)		

Primary medical insurance company

Employer / business name	Business phone	
Employer address (street, city, state, zip)		
Plan name	Insurance company name	
Policy I.D. number	Group name / number	Ins. co. phone

Insurance company address (street, city, state, zip)

Insured party name	Relation	Birth date
--------------------	----------	------------

Insured party sex	☐ Male	☐ Female
-------------------	-------------------------------	---------------------------------

Insured party Social Security Number	Insured party phone
--------------------------------------	---------------------

Insured party address (street, city, state, zip)

Do you have secondary dental or medical insurance?	☐ Yes	☐ No
--	------------------------------	-----------------------------

3 · Health History

Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care you will be receiving. Your answers are for our records only and will be considered confidential.

Reason for today's office visit

Height	Weight
--------	--------

Are you in good health?	☐	Yes	☐	No
Any changes in your general health in the past year?	☐	Yes	☐	No
Are you under the care of a physician?	☐	Yes	☐	No
Illness, operation, or hospitalized in the past five years?	☐	Yes	☐	No
Unhealed / recurrent injuries, inflamed areas, growths or sore spots in or around your mouth?	☐	Yes	☐	No
Do you have a prosthetic joint / implant?	☐	Yes	☐	No
Heart valve replacement or vascular graft?	☐	Yes	☐	No
Ever had general anesthesia or IV sedation?	☐	Yes	☐	No
You or a family member: unusual or serious reaction to general anesthesia or IV sedation?	☐	Yes	☐	No
Physician or dentist recommended antibiotics prior to dental treatment?	☐	Yes	☐	No

4 · Health History Part 2 — Have you ever had, or do you currently have...

Rheumatic fever	☐	Yes	☐	No	Convulsions / epilepsy	☐	Yes	☐	No
Damaged heart valves / mitral valve prolapse	☐	Yes	☐	No	Stroke	☐	Yes	☐	No
Heart murmur	☐	Yes	☐	No	Thyroid trouble	☐	Yes	☐	No
High blood pressure	☐	Yes	☐	No	Diabetes	☐	Yes	☐	No
Low blood pressure	☐	Yes	☐	No	Low blood sugar	☐	Yes	☐	No
Chest pain / angina	☐	Yes	☐	No	Kidney trouble	☐	Yes	☐	No
Heart attack(s)	☐	Yes	☐	No	High cholesterol	☐	Yes	☐	No
Irregular heart beat	☐	Yes	☐	No	Are you on dialysis?	☐	Yes	☐	No
Cardiac pacemaker	☐	Yes	☐	No	Swollen ankles, arthritis or joint disease	☐	Yes	☐	No
Heart surgery	☐	Yes	☐	No	Osteoporosis / osteopenia	☐	Yes	☐	No
Pneumonia, bronchitis or chronic cough	☐	Yes	☐	No	Osteonecrosis	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Stomach ulcers / acid reflux	☐	Yes	☐	No
Hay fever / sinus problems	☐	Yes	☐	No	COVID-19	☐	Yes	☐	No
Snoring	☐	Yes	☐	No	Contagious diseases	☐	Yes	☐	No

Sleep Apnea / CPAP	☐	Yes	☐	No	Sexually transmitted diseases	☐	Yes	☐	No
Difficult breathing / other lung trouble	☐	Yes	☐	No	Immune system problems (medication / surgery, etc.)	☐	Yes	☐	No
Tuberculosis	☐	Yes	☐	No	Autoimmune disease?	☐	Yes	☐	No
Emphysema	☐	Yes	☐	No	Delay in healing	☐	Yes	☐	No
Do you smoke or vape?	☐	Yes	☐	No	A tumor or growth	☐	Yes	☐	No
Do you use chewing tobacco?	☐	Yes	☐	No	Cancer / radiation therapy / chemotherapy?	☐	Yes	☐	No
Alcohol intake?	☐	Yes	☐	No	Chronic fatigue / night sweats	☐	Yes	☐	No
Blood transfusion	☐	Yes	☐	No	Are you on a diet?	☐	Yes	☐	No
Blood disorder such as anemia	☐	Yes	☐	No	History / treatment for alcohol use disorder	☐	Yes	☐	No
Bruise easily	☐	Yes	☐	No	History / treatment for marijuana or substance use disorder	☐	Yes	☐	No
Bleeding tendency / abnormal bleed	☐	Yes	☐	No	Contact lenses	☐	Yes	☐	No
Hepatitis, jaundice, or liver disease	☐	Yes	☐	No	Eye disease / glaucoma	☐	Yes	☐	No
Infectious mononucleosis	☐	Yes	☐	No	Mental health problems / anxiety / depression	☐	Yes	☐	No
Gallbladder trouble	☐	Yes	☐	No	A removable dental appliance	☐	Yes	☐	No
Fainting spells	☐	Yes	☐	No	Pain and clicking of jaws when eating	☐	Yes	☐	No

If you smoke: how much a day?

If alcohol: drinks per day / week

5 · Medications / Allergies

Medications — are you now taking...

Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)	☐	Yes	☐	No
Diet pills / GLP-1s (Trulicity, Ozempic, Byetta, Victoza, Rybelsus, Mounjaro, Wegovy, Saxenda, etc.)	☐	Yes	☐	No
Any natural product, herbal supplement or homeopathic remedy	☐	Yes	☐	No
Bone density meds / RANKL inhibitors / bisphosphonates in the past 12 years (Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, Evista)	☐	Yes	☐	No

Tranquilizers, sleeping pills, anti-depressants, narcotics taken regularly — please list

Pain management / recovery — currently taking:

Select all that apply

☐ Methadone
 ☐ Suboxone
 ☐ Oxycodone
 ☐ Fentanyl
 ☐ Other

Treating doctor

All current medications, drugs, or pills (name, dose, frequency)

Are you allergic to, or have you had a reaction to...

Local anesthetic (numbing meds.)	☐	Yes	☐	No	Codeine or other narcotics	☐	Yes	☐	No
Penicillin	☐	Yes	☐	No	Latex	☐	Yes	☐	No
Other antibiotics	☐	Yes	☐	No	Soy	☐	Yes	☐	No
Sulfa drugs	☐	Yes	☐	No	Eggs / yolk	☐	Yes	☐	No
Sodium pentothal / Valium / other tranquilizers	☐	Yes	☐	No	Sulfites	☐	Yes	☐	No
Aspirin	☐	Yes	☐	No	Any other known allergies?	☐	Yes	☐	No
Amoxicillin	☐	Yes	☐	No					

Other (non-drug) allergies — please list

Other medication / antibiotic allergies — please list

6 · Conclusion

Any condition concerning your health the doctor should be told about?

☐ Yes ☐ No

Do you wish to speak to the doctor privately about anything?

☐ Yes ☐ No

Is there a FAMILY history of...

Cancer

☐ Yes ☐ No

Heart disease

☐ Yes ☐ No

Diabetes

☐ Yes ☐ No

Anesthesia problems

☐ Yes ☐ No

Accident information

Is this visit related to an accident?

☐ Yes ☐ No

If yes, what type?

☐ Automobile

☐ Work related

☐ Other

Date of injury

Insurance company handling claim

Claim number

Attorney / adjustor name

Attorney / adjustor phone

Agreements & Signatures

Verification

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient (Parent or Guardian if Minor)

Date

Policy for Appointments Involving Surgery

The day of your appointment, if you are having surgery, there may be driving and / or eating restrictions. The office will review this information with you prior to your procedure. I acknowledge that I have read and I understand the policy above.

Signature of patient (Parent or Guardian if Minor)

Date

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient (Parent or Guardian if Minor)

Date

Release & Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient (Parent or Guardian if Minor)

Date

Authorization

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

I permit the office to communicate with me via text message on my cell phone. ☐ Yes ☐ No

Signature of patient (Parent or Guardian if Minor) Date

Notice of Privacy Practices

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient (Parent or Guardian if Minor) Date
