BILLINGS ORAL SURGERY
& DENTAL IMPLANT CENTER

General Patient Information

Date: _____

Patient Full Name: _____ _____ _____
First M.I. Last

Sex:_____ Age: _____ Date of Birth: _____ Soc. Sec. #: _____
Month/Day/Year (If needed for filing insurance)

☐ Married ☐ Single ☐ Minor Parent Name (if minor): _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Referred By: _____ ☐ Doctor ☐ Relative ☐ Friend

Responsible Party Info/Insurance Subscriber Info

Full Name: _____ Date of Birth: _____

Soc. Sec. #: _____ Phone #: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Dental Insurance Carrier: _____

Member ID#: _____ Group ID#: _____

Medical Insurance Carrier: _____

Member ID#: _____ Group ID#: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize payment directly to the undersigned doctor of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization.

Signature: _____ Date: _____

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Medical History

Name: _____

Height: _____ Weight: _____ Age: _____

MEDICATIONS & ALLERGIES

- Please list all current medications, including herbal/holistic remedies, vitamins, or over-the-counter medications:

- Are you allergic to any medications? ☐ Yes ☐ No

- Please list all known allergies:

- Are you in good health? ..... ☐ Yes ☐ No
- Has there been any change in your health in the past year? ..... ☐ Yes ☐ No
- Date of last physical exam: _____
- Are you now under the care of a physician? ..... ☐ Yes ☐ No
  If yes, for what condition? _____
  Physician's full name: _____
- Have you had any serious illness, operation, or hospitalization? ..... ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had any complications after an operation or anesthetic? ..... ☐ Yes ☐ No
- Are you allergic to latex? ..... ☐ Yes ☐ No
- Do you have or have you ever had any of the following diseases or problems?

☐ Heart Trouble	☐ Osteoporosis
☐ Heart Murmur	☐ Diabetes
☐ High Blood Pressure	☐ Thyroid Problems
☐ Asthma	☐ Bleeding Problems
☐ Allergies	☐ Anemia
☐ Anxiety	☐ Hepatitis
☐ Depression	☐ Kidney Disease
☐ Seizures	☐ Cancer

- Other health problem(s) not listed above:

FEMALES ONLY:

- Are you pregnant? ..... ☐ Yes ☐ No
- Are you taking birth control? ..... ☐ Yes ☐ No

NOTICE: If you are on birth control pills, be advised that antibiotics interfere with the birth control effectiveness. Use other precautions until your next menstrual period.