Institute Of Facial Surgery (IOFS)
LANCE F. GRENEVICKI, MD, FACS, DDS
Oral and Maxillofacial Surgery • Facial Cosmetic Surgery
1093 South Wickham Road • West Melbourne, Florida 32904 • (321) 674-3900 • Fax (321) 722-3303

PATIENT REGISTRATION

Date:*m/d/yr*_____

Patient's Name:*last,first*_____ Sex_____
Social Sec. #_____ Birth Date_____ Age_____
Address_____ City_____ State_____ Zip Code_____
Home Phone_____ Business Phone_____
Place of Employment_____ Address_____ Occupation_____
Name(s) of Spouse or Parents:*last,first*_____ Social Sec. #_____
Place of Employment of Spouse or Parents_____ Business Phone_____
_____ Business Phone_____
Closest Relative or Friend (not residing with patient)*last,first* _____ Phone_____
Who referred you to the office?_____
Family Dentist's Name_____ Physician's Name_____
Have you ever been a patient in our office?_____ When?_____

INSURANCE INFORMATION

1st Dental Insurance

Company_____
Policy Holder (Employee)_____
Group/Policy Number_____
Certificate or ID Number_____
Policy Holder's Social Sec. #_____
Address of Insurance Company_____
_____

Medical Insurance

_____
_____
_____
_____
_____
_____
_____

2nd Dental Insurance

Company_____
Policy Holder (Employee)_____
Group/Policy Number_____
Certificate or ID Number_____
Policy Holder's Social Sec. #_____
Address of Insurance Company _____
_____

Medical Insurance

_____
_____
_____
_____
_____
_____
_____

All professional services provided are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient (or parent, if minor child) is responsible for all fees, regardless of insurance coverage. It is expected that all fees will be paid at the time of services unless other arrangements have been made in advance.

CONSENT FOR USE OF PHOTOGRAPHS OR IMAGES

I hereby grant permission for the use of any illustrations, photographs, or imaging records, for the limited and specific use of same in scientific and professional publications, journals and presentations at any time following my treatment.
_____ YES _____ NO (Please Initial)

FINANCIAL RESPONSIBILITY/INSURANCE AUTHORIZATION

I authorize the release of any medical/dental and personal information necessary for my treatment and processing of insurance claims if applicable to necessary physicians, hospitals, laboratories and family members. I also request payment of government/private insurance benefits to the doctor. I understand that I am responsible for my total bill, including any portion of those charges not covered by my insurance plan.

Date:*m/d/yr*_____ Signature___*Sign in office*_____
(If patient is a minor, parent or legal guardian must sign)

(Check One) HEALTH QUESTIONNAIRE

YES NO 1. Are you currently, or have you been under the care of a physician or hospitalized in the past 2 years? If so, for what reason? _____

YES NO 2. Please list any drugs, medications, pills (including birth control) you are taking: _____

YES NO 3. Are you allergic to anything: Penicillin, drugs, Medications? Please list:_____

YES NO 4. Have you ever had any other adverse drug reaction? Please list:_____

YES NO 5. Have you taken cortisone or other steroid drugs? Please list:_____

6. Have you ever had any of the following? (Check the box)

YES	NO		YES	No		YES	NO	
☐	☐	Heart Trouble, Arrhythmia	☐	☐	Porphyria	☐	☐	Emphysema, Bronchitis
☐	☐	Heart Attack	☐	☐	Cancer or Tumor	☐	☐	Asthma
☐	☐	Chest Pain	☐	☐	Stroke	☐	☐	Hay Fever
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Sinus Problem
☐	☐	Circulation Problem	☐	☐	Kidney/Bladder Problem	☐	☐	Recent Cold
☐	☐	Heart Murmur	☐	☐	Epilepsy	☐	☐	Hepatitis, Liver Condition
☐	☐	Rheumatic Fever	☐	☐	Psychiatric Treatment	☐	☐	Excessive Bleeding
☐	☐	Thyroid Condition	☐	☐	Fainting	☐	☐	Herpes, Cold Sores
☐	☐	Anemia, Sickle Cell	☐	☐	Glaucoma	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Ulcer, Stomach Trouble	☐	☐	HIV

YES NO 7. Have you had any other serious illness? Please list:?_____

YES NO 8. Do you have any family history of disease?_____

YES NO 9. (Women) Are you pregnant? How many months?_____

YES NO 10. Have you ever had any operations? Please list:_____

YES NO 11. Have you ever had any problem with local or general anesthesia? Please describe:_____

YES NO 12. Do you smoke? Packs per day?_____Do you have a "smoker's cough"?_____

YES NO 13. Alcohol/Drugs?_____

YES NO 14. Are you wearing contact lenses?*type*_____Dentures?_____

YES NO 15. Have you had anything at all to eat or drink in the last 6 hours?_____

I hereby certify that the answers I have given on this questionnaire are true and correct to the best of my knowledge. *initials*

This office is a surgicenter regulated pursuant to the rules of The Board Of Medicine as set forth in rule Chapter 64B8, F.A.C.

DATE:*m/d/yr*_____ Signature_____*Sign in office*_____
(Patient's Signature)

DATE:*m/d/yr*_____ Signature_____*Sign in office*_____
(Physician's Signature)