



# Patient Registration

Please fill out this registration sheet and fax to our office at the time of consultation. Form must be returned within 7 days of appointment. Fax #: 318-759-0821

Today's date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dentist: \_\_\_\_\_

Appointment date: \_\_\_\_\_ Time: \_\_\_\_\_ Approximate length of procedure: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex \_\_\_\_\_

Patient's home number: \_\_\_\_\_ Cell: \_\_\_\_\_

Medical History: *Patient to complete*

1. List all medications you are currently taking or have taken recently. Be sure to include all over-the-counter drugs.

Medications	Date/Time of last dose	Medications	Date/Time of last dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any previous surgeries or procedures in which you have had anesthesia. List any problems you experienced as a result of anesthesia.

Previous Surgery / Year	Reaction	Previous Surgery / Year	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

2. List any allergies to food, drugs, or latex \_\_\_\_\_

3. Do **YOU** have a history of any of the following? If "yes" please explain.

- |     |    |   |
|-----|----|---|
| Yes | No | Any family with a reaction to anesthesia? _____                             |
| Yes | No | Stroke, Seizures, other neurologic problem? _____                           |
| Yes | No | High blood pressure, heart failure, chest pain, irregular heart beat? _____ |
| Yes | No | Asthma, TB, sleep apnea, recent cold or cough? _____                        |
| Yes | No | Hepatitis, bleeding problems, liver problems? _____                         |
| Yes | No | Hiatal hernia, ulcers, frequent heart burn? _____                           |
| Yes | No | Diabetes or low blood sugar? _____  |
| Yes | No | Problems with kidneys? _____  |
| Yes | No | Other medical history? _____  |

I understand that if my appointment is not cancelled at least 2 business days in advance of my appointment date, if there is a violation of the fasting guidelines, or if I arrive more than 15 minutes after my scheduled appointment time that I will be rescheduled and charged the minimum 1 hour anesthesia charge.

Patient signature: \_\_\_\_\_

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