



**DIXIE ORAL MAXILLOFACIAL  
& IMPLANT SURGERY**

**John H. Mizukawa, D.D.S. Wayne H. Dudley, D.D.S.**  
BOARD CERTIFIED, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

**Matthew K. Mizukawa, D.M.D.**

**St. George Office:**  
1308 East 900 South, Unit A  
St. George, UT 84770 435-673-1554

**Cedar City Office:**  
415 N. Main, Ste. 204  
Cedar City, UT 84721 435-867-1474

**PATIENT REGISTRATION / MEDICAL HISTORY**

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cellular / Daytime Phone: \_\_\_\_\_

Patient: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Last Name First Name Middle Initial

P.O. Box /  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ S.S. # \_\_\_\_\_

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

Spouse Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Closest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Heart Problems	___	___	Sinus Problems	___	___	Nervous Problems
___	___	Artificial Heart Valves or Artificial Joints	___	___	Stroke	___	___	Psychiatric Care
___	___	Rheumatic Fever, Murmur	___	___	Blood disease	___	___	Chemical Dependency
___	___	High Blood Pressure	___	___	Bleeding Disorder	___	___	Back Problems
___	___	Shortness of Breath	___	___	Hepatitis, Jaundice or Liver Disease	___	___	Arthritis
___	___	Circulatory Problems	___	___	Kidney Disease	___	___	Venereal Disease
___	___	Lung Disorder	___	___	Chronic Diarrhea	___	___	AIDS / Other Immuno- suppressive Disorder
___	___	Asthma	___	___	Ulcer	___	___	Allergies to Anesthetic
___	___	Thyroid Disease	___	___	Diabetes	___	___	Allergies to Medicines or Drugs
___	___	Epilepsy	___	___	Special Diet	___	___	General Allergies
___	___	Headaches	___	___	Recent Weight Loss	___	___	
___	___	Swollen Neck Glands	___	___	Cancer			
			___	___	Radiation Treatment			

Do you have any drug allergies or have you ever had any adverse reaction to any medication? \_\_\_\_\_ If so, please explain \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_

Are you taking any medications at this time? \_\_\_\_\_ If so, what? \_\_\_\_\_

Have you taken any oral or IV medications called Bisphosphonates? (i.e. Zometa, Aredia, Fosamax, Actonel, Boniva) \_\_\_ Yes \_\_\_ No

Are you under the care of a physician? \_\_\_ Yes \_\_\_ No For what condition? \_\_\_\_\_

Do you use tobacco? Smoke: Cigarettes Cigars Pipe Smokeless: Chewing tobacco Snuff or "Dip" Frequency: \_\_\_\_\_

Do you suspect that you are pregnant? \_\_\_ Yes \_\_\_ No Trimester 1 2 3 Are you nursing? \_\_\_ Yes \_\_\_ No

Is there anything else we should know about your medical history including the use of herbs or health supplements \_\_\_\_\_

### PERSON RESPONSIBLE FOR PAYMENT

If patient is responsible for the account, circle "Self" and write "Same as front" on "Name" line  
(Must be over 18 years of age and preferably the same person signing the Financial Policy)

Name \_\_\_\_\_ (Self, Spouse, Parent, Guardian) Circle one

P.O. Box /

Street Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Cellular / Daytime Phone: \_\_\_\_\_

Responsible Party's Drivers License Number: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Date of Birth \_\_\_\_\_

### INSURANCE INFORMATION

**Medical / Dental Insurance** is a contract between the insured and the insurance carrier. The patient is responsible to our office for the total fees charged for services rendered. We are happy to bill your insurance company as a service to you if you supply us with the necessary information.

**Primary** Medical / Dental (Circle One)

Name of Policy Holder: \_\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_\_

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

Policy Holder S.S.#: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Insur Co: \_\_\_\_\_

Address \_\_\_\_\_

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

**Secondary** Medical / Dental (Circle One)

Name of Policy Holder: \_\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_\_

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

Policy Holder S.S.#: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Insur Co.: \_\_\_\_\_

Address \_\_\_\_\_

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

I have read and / or been furnished with a copy of the "Notice of Privacy Practices" for Dixie Oral, Maxillofacial and Implant Surgery.

The information on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omission that I may have made in completing the form. I agree to pay in full all fees that are incurred during my dental treatment or treatment of the above patient. I also understand that I am responsible for any balance not paid by my insurance company.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian's Signature

\_\_\_\_\_  
Date

(Updated March 2008)