PATIENT NAME: _____ DATE:_____

MEDICAL HISTORY

Primary Physician's Name: _____ Phone: _____

Are you under a physician's care now? YES NO Why: _____

Who: _____ Phone: _____

Have you ever been hospitalized or had a **major operation**? YES NO Discuss: _____

Have you ever had a **serious injury** to your **head or neck**? YES NO Discuss: _____

Are you taking any **medications, pills or drugs**? YES NO Please List: _____

_____

_____

Are you on a **special diet**? YES NO Discuss: _____

Are you **allergic** to any medications or substances? YES NO Please mark below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other: _____

Women Please Mark: Pregnant / trying to get pregnant YES NO Nursing YES NO Taking oral contraceptives YES NO

Discuss: _____

Current Weight: _____

Do you have or have you ever had any of the following? Please Circle: Yes (Y) No (N)

*** If yes to any of the starred conditions, please call prior to your appointment, premedication may be required.**

Y N Heart Trouble / Disease
Y N Heart Murmur*
Y N Irregular Heart Beat
Y N Angina / Chest pain
Y N Heart Attack / Failure
Y N Congenital Heart Disease
Y N Mitral Valve Prolapse*
Y N Scarlet Fever
Y N Rheumatic Fever*
Y N Artificial Heart Valve*
Y N Heart Pace Maker *
Y N Heart Surgery
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Blood Disease
Y N Unexplained Fever
Y N Smoke or Chew
Y N Bruise Easily
Y N Anemia
Y N Excessive Bleeding

Y N Sickle Cell Disease
Y N Hemophilia (Bleeding Problem)
Y N Leukemia
Y N Recent Blood Transfusion
Y N Swelling of Limbs
Y N Lung Disease
Y N Breathing Problems
Y N Shortness of Breath
Y N Frequent Cough
Y N Hay Fever
Y N Sinus Trouble
Y N Asthma
Y N Bloody Sputum
Y N Emphysema
Y N Tuberculosis
Y N Cancer
Y N X-ray Treatment (Radiation)
Y N Chemotherapy
Y N Stomach / Intestinal Disease
Y N Ulcers

Y N Recent Weight Loss
Y N Frequent Diarrhea
Y N Diabetes
Y N Excessive Thirst
Y N Hypoglycemia
Y N Liver Disease
Y N Hepatitis A (Infectious)
Y N Hepatitis B or C
Y N Night Sweats
Y N Yellow Jaundice
Y N Kidney Disease
Y N Renal Disease
Y N Thyroid Disease
Y N Parathyroid Disease
Y N Arthritis / Gout
Y N Rheumatism
Y N Pain in the Jaw Joints
Y N Cortisone Medicine
Y N Artificial Joint*
Y N Venereal Disease

Y N AIDS
Y N HIV Positive
Y N Genital Herpes
Y N Drug Addiction /Alcoholism
Y N Tattoos
Y N Cold Sores
Y N Fever Blisters
Y N Herpes
Y N Stroke
Y N Convulsions
Y N Epilepsy or Seizures
Y N Fainting or Dizziness
Y N Glaucoma
Y N Tumors or Growths
Y N Nervousness
Y N Psychiatric Care
Y N Alzheimer's Disease
Y N Allergies (Medicines)
Y N Allergies (Pollen / Dust)
Y N Hives or Rash
Y N Needs Premedication

Have you ever had any other serious illness not checked above? Y N Discuss: _____

Do you wish to talk to the dentist privately about any problems? Y N Discuss: _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____

MEDICAL UPDATES: I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	☐ None	_____	Dr. _____
_____	_____	☐ None	_____	Dr. _____
_____	_____	☐ None	_____	Dr. _____
_____	_____	☐ None	_____	Dr. _____
_____	_____	☐ None	_____	Dr. _____

QUAD COUNTY ORAL & MAXILLOFACIAL SURGERY
Patient Registration

Today's Date: _____

Patient Information

Full Patient Name: _____ Gender (circle one): Male Female

Date of Birth: _____ Age: _____ SS#:_____ Marital Status: _____

Primary Phone #: _____ Other Phone #: _____

Full Address: _____

Employer / School: _____ Employer / School Phone: _____

Referring Dentist / Doctor: _____

Primary Insurance

Dental Insurance Co: _____

Group #: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

Full Address: _____

Subscriber SS #: _____ Employer: _____

Med Insurance Co: _____

Group #: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

Full Address: _____

Subscriber SS #: _____ Employer: _____

Secondary Insurance

Dental Insurance Co: _____

Group #: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

Full Address: _____

Subscriber SS #: _____ Employer: _____

Med Insurance Co: _____

Group #: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

Full Address: _____

Subscriber SS #: _____ Employer: _____

Emergency Contact / Parent or Guardian

Full Name: _____ Date of Birth: _____

Primary Phone #: _____ Other Phone #: _____

Full Address: _____

Relationship to Patient: _____