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, neck or have limited range of motion**? YES NO Discuss: _____

_____

Are you taking any **medications, over the counter drugs, herbals, medical marijuana, etc**? 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: _____ Current Height: _____

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 Hemophilia (Bleeding Problem)	Y N Recent Weight Loss	Y N Venereal Disease
Y N Heart Murmur*	Y N Recent Blood Transfusion	Y N Frequent Diarrhea	Y N AIDS / HIV Positive
Y N Irregular Heart Beat	Y N Swelling of Limbs	Y N Diabetes I or II	Y N Genital Herpes
Y N Angina / Chest pain	Y N Lung Disease	A1C _____	Y N Drug Addiction /Alcoholism
Y N Heart Attack / Failure	Y N Breathing Problems	Y N Excessive Thirst	Y N Tattoos
Y N Congenital Heart Disease	Y N Shortness of Breath	Y N Hypoglycemia	Y N Cold Sores
Y N Mitral Valve Prolapse*	Y N Frequent Cough	Y N Liver Disease	Y N Fever Blisters
Y N Scarlet Fever	Y N Sleep Apnea	Y N Hepatitis A (Infectious)	Y N Herpes
Y N Rheumatic Fever*	Y N Hay Fever	Y N Hepatitis B or C	Y N Stroke
Y N Artificial Heart Valve*	Y N Sinus Trouble	Y N Night Sweats	Y N Glaucoma
Y N Heart Pace Maker*	Y N Asthma	Y N Yellow Jaundice	Y N Convulsions
Y N Heart Surgery	Y N Bloody Sputum	Y N Kidney Disease	Y N Epilepsy or Seizures
Y N High Blood Pressure	Y N Emphysema	Y N Renal Disease	Y N Fainting or Dizziness
Y N Low Blood Pressure	Y N Tuberculosis	Y N Thyroid Disease	Y N Nervousness
Y N Blood Disease	Y N Tumors or Growths	Y N Parathyroid Disease	Y N Psychiatric Care
Y N Unexplained Fever	Y N Cancer	Y N Arthritis / Gout	Y N Alzheimer's Disease
Y N Smoke, Vape or Chew	Y N Leukemia	Y N Osteoporosis	Y N Allergies (Medicines)
Y N Bruise Easily	Y N Radiation	Y N Rheumatism	Y N Allergies (Pollen / Dust)
Y N Anemia	Y N Chemotherapy	Y N Pain in the Jaw Joints	Y N Hives or Rash
Y N Excessive Bleeding	Y N Stomach / Intestinal Disease	Y N Cortisone Medicine	Y N Gagger
Y N Sickle Cell Disease	Y N Ulcers	Y N Artificial Joint*	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	x_____	Dr. _____
_____	_____	☐ None	x_____	Dr. _____
_____	_____	☐ None	x _____	Dr. _____
_____	_____	☐ None	x_____	Dr. _____

QUAD COUNTY ORAL & MAXILLOFACIAL SURGERY
Patient Registration

Today's Date: _____

Patient Information

Full Patient Name: _____ Gender: ☐ Male ☐ Female

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

Primary Phone #: _____ Cell Phone #: _____

Email: _____ Preferred method of contact: ☐ Text ☐ Email

Full Address: _____

Employer / School: _____ Employer / School Phone: _____

Referring Dentist / Doctor: _____ Pharmacy / City: _____

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: _____

CONTINUE ONTO BACK