

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, 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 Sickle Cell Disease	Y N Recent Weight Loss	Y N AIDS / HIV Positive
Y N Heart Murmur*	Y N Hemophilia (Bleeding Problem)	Y N Frequent Diarrhea	Y N Sleep Apnea
Y N Irregular Heart Beat	Y N Recent Blood Transfusion	Y N Diabetes I or II	Y N Genital Herpes
Y N Angina / Chest pain	Y N Swelling of Limbs	A1C: _____	Y N Drug Addiction /Alcoholism
Y N Heart Attack / Failure	Y N Lung Disease	Y N Excessive Thirst	Y N Marijuana
Y N Congenital Heart Disease	Y N Breathing Problems	Y N Hypoglycemia	Y N Tattoos
Y N Mitral Valve Prolapse*	Y N Shortness of Breath	Y N Liver Disease	Y N Cold Sores
Y N Scarlet Fever	Y N Frequent Cough	Y N Hepatitis A (Infectious)	Y N Fever Blisters
Y N Rheumatic Fever*	Y N Hay Fever	Y N Hepatitis B or C	Y N Herpes
Y N Artificial Heart Valve*	Y N Sinus Trouble	Y N Night Sweats	Y N Stroke
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 Glaucoma
Y N Blood Disease	Y N Cancer	Y N Parathyroid Disease	Y N Tumors or Growths
Y N Unexplained Fever	Y N Leukemia	Y N Arthritis / Gout	Y N Nervousness
Y N Smoke, Chew or Vape	Y N Radiation	Y N Osteoporosis	Y N Psychiatric Care
Y N Bruise Easily	Y N Chemotherapy	Y N Rheumatism	Y N Alzheimer's Disease
Y N Anemia	Y N Stomach/Intestinal Disease	Y N Pain in the Jaw Joints	Y N Allergies (Medicines)
Y N Excessive Bleeding	Y N Ulcers	Y N Cortisone Medicine	Y N Allergies (Pollen / Dust)
Y N History of anesthesia complications	Y N Family history of Anesthesia complications	Y N Artificial Joint*	Y N Hives or Rash
		Y N Venereal Disease	Y N Gagger
			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
_____	_____ <input type="checkbox"/> None	_____	Dr. _____
_____	_____ <input type="checkbox"/> None	_____	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: \_\_\_\_\_ Name of 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: \_\_\_\_\_