## SOUTH SHORE ORAL SURGERY ASSOCIATES, P.C

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DIPLOMATES OF THE AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY

### MEDICAL HISTORY INFORMATION

PATIENT'S NAME: _____DOB: _____AGE: _____

ADDRESS:_____

HOME PHONE: _____CELL PHONE: _____WORK PHONE: _____

EMERGENCY CONTACT NAME: _____PHONE NUMBER: _____

DENTAL INSURANCE NAME & ADDRESS: _____

DENTAL INSURANCE ID # _____ SOCIAL SECURITY # _____

PHARMACY NAME, ADDRESS & PHONE NUMBER _____

REFERRED BY: _____

I WILL BE PAYING TODAY BY: CASH_____CHECK_____CREDIT CARD_____

1. HAVE YOU EVER HAD ANY OF THE FOLLOWING: **PLEASE ANSWER YES OR NO**

| | **YES** | **NO** | | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|---|---|---|
| RHEUMATIC FEVER | | | KIDNEY DISEASE | | | LUNG DISEASE | | |
| HEART ATTACK/ HEART TROUBLE/MURMUR | | | CANCER/RADIATION/CHEMO | | | EPILEPSY/SEIZURES | | |
| STROKE | | | DIABETES | | | HEPATITIS | | |
| HIGH BLOOD PRESSURE | | | ANEMIA | | | H.I. V | | |
| BLEEDING DISORDER | | | OSTEOPOROSIS | | | ARE YOU PREGNANT ? | | |
| LIVER TROUBLE | | | ASTHMA | | | OTHER | | |

2. DO YOU TAKE ANY MEDICATIONS? _____PLEASE LIST: _____

_____

3.DO YOU PRE-MEDICATE BEFORE DENTAL PROCEDURES? _____

4. DO YOU HAVE ANY ALLERGIES? _____PLEASE LIST: _____

5.HAVE YOU EVER EXPERIENCED PROLONGED BLEEDING OR TAKE ANY BLOOD THINNERS? _____

6.HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE PAST 2 YEARS? _____

7.DO YOU HAVE A COUGH, COLD, SINUS TROUBLE OR RESPIRATORY PROBLEMS? _____

8.HAVE YOU HAD ANY SURGICAL PROCEDURES OR JOINT REPLACEMENTS? _____

**SIGNATURE: _____DATE: _____**