Oral Surgery Medical History Form

Patient Information

Full Name

Date of Birth

Phone

Email

Address

City

State

ZIP Code

Emergency Contact

Name

Relationship

Phone

Primary Physician

Physician Name

Phone

Medical History

- [ ] Diabetes
- [ ] Asthma
- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ]

Other

If you checked 'Other', please specify

Allergies

Current Medications

Have you ever been hospitalized?

Yes

No

If yes, reason

Dental History

Have you had previous oral surgeries?

Yes

No

If yes, please explain

Main concern or reason for visit

Signature

Signature

Date