CENTRAL NEW HAMPSHIRE ORAL SURGERY, P.A.

Paul E. Levy, DMD
Oral and Maxillofacial Surgeon
Board Certified, Am. Bd. OMFS

PATIENT HEALTH HISTORY AND REGISTRATION

Patient Name _____ M____ F____ Date of Birth _____
Mailing Address _____ City _____ Zip Code _____
Street Address_____ City _____ Zip Code_____
Home Phone # _____ Work Phone #_____ Cell #_____
Emergency Contact: _____

Your Dentist _____ Your Physician/PCP _____ Who Referred you to us: _____
Are Any Family Members Previous Patients? No ___ Yes ___ Family Member Name _____
Patient SS# _____ Marital Status M S D W
Patient Employed By_____ Work Address _____

I Will Be Paying Today By Check_____ Cash_____ M/C_____ Visa_____ Discover_____ American Express _____ CareCredit _____

If someone other than the patient is responsible for payment please complete:

Father/Guardian/Guarantor

Name
_____
Address_____
_____
Home Phone # _____ Work Phone # _____
Employer _____
SS# _____ DOB _____

Mother/Guardian/Guarantor

Name
_____
Address _____
_____
Home Phone # _____ Work Phone # _____
Employer _____
SS# _____ DOB _____

Medical History *(Please Check No Or Yes)*

High Blood Pressure	No ____	Yes ____		Bleed A Long Time When Cut	No ____	Yes ____
Rheumatic Fever	No ____	Yes ____		Diabetes	No ____	Yes ____
Heart Murmur	No ____	Yes ____		Been On Steroids	No ____	Yes ____
Heart Valve	No ____	Yes ____		Kidney Disease	No ____	Yes ____
Chest Pain / Heart Attack	No ____	Yes ____		Tumor/Cancer	No ____	Yes ____
Lung Disease/Bronchitis	No ____	Yes ____		Problems During Anesthesia	No ____	Yes ____
Asthma	No ____	Yes ____		Do You Take Birth Control Pills	No ____	Yes ____
Seizures	No ____	Yes ____		Might You Be Pregnant?	No ____	Yes ____
TMJ (Jaw Joint)	No ____	Yes ____		Osteoporosis (thin bone)	No ____	Yes ____

I Smoke _____ Packs Per Day Other Problems_____

I am Allergic to _____
My Current Medications are (Including Herbal Remedies)_____
_____
Previous Surgery *(Not just oral surgery)* _____

Are you or do you believe that you could be HIV / AIDS Virus "Positive"	No	Yes
History of Alcohol and /or Drug Problems	No	Yes
Do you have or have you had Hepatitis A,B, or C or Liver Disease	No	Yes
Do you have an Artificial or Donor Heart Valve or an Artificial Hip or Knee Joint	No	Yes
Can you climb at least one flight of stairs without stopping because you're short of breath	No	Yes
Do you have "Sleep Apnea" or use "CPAP" at night?	No	Yes
Have you ever received chemotherapy for any type of cancer?	No	Yes
Do you wish to speak privately to the doctor about your medical/health situation?	No	Yes

Please use back side if you have additional medical information.

Legally Responsible Party _____ Date _____