STEVEN R. SCHWARTZ, DDS
NY Oral & Maxillofacial Surgeon, P.C.

Patient Registration / Medical History
(Please Print)

Date_____ Cell Phone_____ Home Phone_____

Patient_____
Last Name First Name Initial E-mail Address

Street Address_____
Street Address City State Zip Code

Sex: ❑ Male ❑ Female Age_____ Birthdate_____ ❑Single ❑Married ❑Widowed ❑Separated ❑Divorce

Name of General Dentist_____ Date of Last Visit_____

Physician's Name_____ Date of Last Physical _____

Are you currently under the care of a physician?_____

If so, what is the condition being treated_____

Has there been any change in your general health within the past year? ❑Yes ❑No

Have you had any serious illness or operation?❑Yes ❑No Have you been hospitalized within the past 5 years? ❑Yes ❑No

If so, what was the illness or operation _____

Do you have or have you had any of the following diseases or problems (check all boxes either yes or no)

YES	NO		YES	NO		YES	NO	
❑	❑	Heart Murmur	❑	❑	Headaches	❑	❑	Swollen Neck Gland
❑	❑	High Blood Pressure	❑	❑	Hepatitis, Jaundice or Liver Disease	❑	❑	Rheumatic Fever
❑	❑	Low Blood Pressure	❑	❑	Cancer	❑	❑	Sinus Problem
❑	❑	Circulatory Problems	❑	❑	Psychiatric Care	❑	❑	AIDS/HIV
❑	❑	Nervous Problems	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Disease
❑	❑	Radiation Treatment	❑	❑	Allergies to Anesthetics	❑	❑	Stroke
❑	❑	Artificial Heart Valves or Joints	❑	❑	Allergies to Medicine or Drugs	❑	❑	Stomach Ulcer
❑	❑	Recent Weight Loss	❑	❑	General Allergies	❑	❑	Venereal Disease
❑	❑	Back Problems	❑	❑	Blood Disease	❑	❑	Chemical Dependency
❑	❑	Diabetes	❑	❑	Arthritis	❑	❑	Hemophilia
❑	❑	Respiratory Disease/Asthma	❑	❑	Congenital Heart Lesions	❑	❑	Tuberculosis
❑	❑	Glaucoma	❑	❑	Inflammatory Rheumatism	❑	❑	Kidney Trouble
❑	❑	Persistent Cough or Cough Up Blood						
❑	❑	Epilepsy or Fainting Spells	❑	❑	Special Diet			
❑	❑	Cardiovascular Disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis)						

Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ❑Yes ❑No

Have you ever required a blood transfusion? ❑Yes ❑No If so, explain_____

Do you have any blood disorders, such as anemia? ❑Yes ❑No

Have you had surgery or x-ray treatment for tumor, growth, or other condition of your mouth or lips? ❑Yes ❑No

Are you currently taking any drugs or medicine? ❑Yes ❑No If so, what_____

_____

_____

Are you **now** taking or have you taken any of the following in the **past year**?

Nitroglycerin ❑Yes ❑No Anticoagulants (blood thinners) ❑Yes ❑No Steroids (Cortisone) ❑Yes ❑No

Tranquilizers ❑Yes ❑No High blood pressure medication ❑Yes ❑No Bisphosphonates (Fosomax) ❑Yes ❑No

Antihistamines ❑Yes ❑No Insulin, Tolbutamide or similar drugs ❑Yes ❑No Digitalis or drugs for heart trouble ❑Yes ❑No

Are you allergic or have you reacted adversely to any medicines or drugs ❑Yes ❑No If so, explain _____

_____

Do you smoke? ❑Yes ❑No ____per day for_____years Alcohol consumed: daily ____ weekly _____ monthly_____

Do you have any disease, condition, or problem not listed above ❑Yes ❑No If so, explain _____

_____

WOMEN: Are you pregnant? ❑Yes ❑No Are you taking oral contraceptives (birth control pills) ❑Yes ❑No

Are you breast feeding? ❑Yes ❑No Do you have any problems associated with your menstrual period? ❑Yes ❑No

MEN: Prostate gland problems ❑Yes ❑No

I certify that the above information is true and accurate, and that there have been no omissions for my medical history. I consent to the taking of clinical photographs in the course of diagnostic and surgical procedures for use for treatment, educational or research purposes. I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating dentist for the services provided. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____