

MEDICAL HISTORY

Patient's name: _____

DOB: _____

Address: _____

City/State/Zip: _____

Occupation: _____

Mobile Phone #: _____

General Dentist: _____

Social Security #: _____

Primary Physician: _____

Pharmacy/ phone: _____

Please mark if you have any of the following conditions:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Current/Past smoker | <input type="checkbox"/> Pregnant/Breast Feeding |
| <input type="checkbox"/> Heart murmur/MVP | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> COPD | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart stent | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Hepatitis: A, B, or C |
| <input type="checkbox"/> High <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Herpes: Type _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Stomach Ulcers/Colitis | <input type="checkbox"/> Immunocompromised |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Cancer: Type _____ |
| <input type="checkbox"/> Diabetes – Type I or II | date _____ | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chemotherapy/Radiation |

Do you have any other conditions? (Please list) _____

Have you been hospitalized in the past 5 years? _____ **(Reason)** _____

Do you need to pre-medicate before any dental treatment? Yes or No

Have you ever taken any medication for osteoporosis (i.e. Actonel, Boniva, Prolia, etc...) Yes or No

DENTAL HISTORY

Are you in dental pain? Yes or No

On a scale of 1-10, how much pain are you in? _____

Has this tooth had root canal treatment? Yes, No, or Not Sure

Are you taking medications/supplements? Yes or No

Please List

Do you have any allergies? Yes or No

- | | |
|------------------------------------|--|
| <input type="radio"/> Latex | <input type="radio"/> Local anesthetic |
| <input type="radio"/> Penicillin | <input type="radio"/> Ibuprofen/NSAIDS |
| <input type="radio"/> Codeine | <input type="radio"/> Sulfa |
| <input type="radio"/> Other: _____ | |

Our office follows privacy rules set by the American Dental Association and the U.S. Department of Health and Human Services. Federal law requires updates to how some sensitive health records are protected. This may include certain records we receive from other healthcare providers. These records have extra privacy protections and usually cannot be shared without your written permission, unless allowed by law. We are committed to protecting your health information. An emailed copy of the current Notice of Privacy Practices can be sent upon request.

To the best of my knowledge, the questions on this form have been accurately answered. By signing below, you confirm you were offered a copy of our current Notice of Privacy Practices.

Signature of Responsible party: _____

Date: _____