PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma

Y	N	Conditions
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pain In Jaw Joints
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke

Y	N	Conditions
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice
☐	☐	Lung Infection

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

Medications:

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below..

Notes:

Signature: _____ Date: _____

(If Under 18, Parent or Guardian Signature Required)

HIPAA PRIVACY NOTICE

There's been a development in the health industry that requires us to get your written permission in case we ever need to share your treatment information with a specialist, dental lab, or an insurance company. When you sign this form, you give us your approval to share your treatment information and you acknowledge that you are aware of our potential need to do so.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. However, without your signature, we cannot file your insurance or treat you today.

I, _____, have received a copy of this notice of privacy practices. I give my permission should it be necessary to share my treatment information. A copy of this notice and acknowledgement will be kept in my Patient file.

Please Print your Name: _____

Patient Signature: _____

Date: _____

For Office Use Only (Patients should not write below this line):

_____

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

☐ *Individual refused to sign*

☐ *Communication barriers prohibited obtaining acknowledgement*

☐ *An emergency situation prevented us from obtaining acknowledgement*

☐ *Other (Please specify):* _____