MEDICAL HISTORY INFORMATION

Name ____ **Soc Security #** _______________
Last Middle First

Home Address ____ **Zip** ________________

Birth Date __________ **Phone Number** ________________ **Business Phone** ___________________________

Person Financially Responsible for the Account _________________ **Pharmacy Phone #** ________________

Family Information

Spouse Name __________________ Emergency Contact ___________________________________
Whom may we thank for this referral: ____
Purpose for this visit: ____

Patient Medical Information:
Please circle where answer is "**YES** or **NO**"

Date of last dental treatment _________________ **Did it include a full mouth x-ray?** ________________
Is patient in good health? _________________ **Yes** **No**
Are you taking birth control? Yes No (Did you know that birth control pills reduce effectiveness of antibiotics by 50%)
Have you ever been diagnosed as having periodontal (gum) disease? Yes No
Do you have a family physician? _______
Name ___________________________________ **Phone** _________________________________
Has patient been in the hospital in the last two years? ________ **Condition treated** __________________
Do you hate the sound of the dental drill? ______ **Have you ever had trouble getting numb?** ________

Do you take any of the following bone density medications:

Actonel Y N	Zometa Y N	Boniva Y N
Fosamax Y N	Aredia Y	

Are you allergic to any of the following medications?

Local Anesthetics Y N	Aspirin Y N	Codeine Y N
Erythromycin Y N	Penicillin Y N	Any other Drug Y N

Do you have any of the following conditions?

Prosthetic Joints Y N	Excessive Bleeding Y N	Nervous Disorder Y N
Fainting or Dizziness Y N	Sinus Problems Y N	Seizures Y N
Heart Problems Y N	High Blood Pressure Y N	Asthma Y N
Rheumatic Fever Y N	Tuberculosis Y N	Hepatitis (A,B,C) Y N
Diabetes Y N	Aids/HIV Y N	Drug Addiction Y N
Stroke Y N	Malignancies Y N	Low Blood Pressure Y N
Latex Allergies Y N	Seasonal Allergies Y N	Cancer Y N
Osteoporosis Y N	Paget's Disease Y N	Osteogenesis Imperfecta Y N
Infectious Disease Y N	Any other health conditions not listed? Y N	Mersa Y N

Are you taking any Medications now? _________ If so please list: ____________________________________

____

What health condition(s) has the patient had (has) that you feel we should know about?

____

Signature ________________________________ Date ___________ ________________

HIPPA COMPLIANCY

This office follows all current Hippa procedures and guidelines to protect your health information. A copy of the full article is available for you at the front desk if needed. By completing and signing this form you grant this office the authorization to use you protected health information in a manner consistent with current guidelines INITIAL ___________