Date:_____

Medical History

Patient Name:_____D.O.B._____
Home phone:_____ cell:_____ work:_____
Email address:_____
Emergency Contact (Name/Phone Number): _____

Physician Name:_____Number:_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:								
Amoxicillin	Y	N	Erythromycin	Y	N	Metal	Y	N
Aspirin	Y	N	Latex	Y	N	Penicillin	Y	N
Codeine	Y	N	Local Anesthetics	Y	N	Sulfa	Y	N
Other Medication:								

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:								
Acid Reflux/GERDS	Y	N	Chemo/Radiation	Y	N	On Blood Thinner	Y	N
AIDS/HIV	Y	N	Diabetes (type____)	Y	N	Osteoporosis	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N	Respiratory Problems	Y	N
Anxiety	Y	N	Glaucoma	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Hearing Impaired	Y	N	Seasonal Allergies	Y	N
Artificial Joint	Y	N	Heart Murmur	Y	N	Sinus Trouble	Y	N
Artificial Heart Valve/Stent	Y	N	Heart Pacemaker	Y	N	Sleep Apnea	Y	N
Asthma	Y	N	Heart Problems/Trouble	Y	N	Stroke	Y	N
Bleeding Disorder	Y	N	Hepatitis (type____)	Y	N	Thyroid Problem	Y	N
Bone Density prescription	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Cancer	Y	N	High Cholesterol	Y	N	Use Tobacco Products	Y	N
Celiac Disease	Y	N	Kidney Problems/Dialysis	Y	N	Vertigo		

Do you take an antibiotic one hour prior to dental appointments?	Y	N

Please list all prescription medications, supplements or herbals you regularly take:

_____
_____
_____
_____

_ _

Consent for Use and Disclosure of Health Information and Acknowledgement of Receipt of Notice and Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

☐ I have reviewed a copy of this office's Notice of Privacy Practices
☐ I refuse to sign this Acknowledge of Notice of Privacy Practices

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Patient Signature Dentist Signature