Hitchcock Dental

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ DOB: _____Today's Date: _____

Medical Information

Dr Name: _____
Dr Ph#: _____
Date of last physical exam? _____

Are you now, or have you been under the care of a physician (including psychiatrist) during the past 2 years? Yes __ No __

If so, for what were you treated? _____

_____

List medicines or drugs you take or have taken during the past year and for what:

MEDICATIONS	FOR WHAT?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you been hospitalized in the past 2 years? If so, for what were you hospitalized?

_____

_____

_____

Have you ever had a serious injury? Yes __ No __ explain: _____

Do you have any drug allergies? Yes __ No __ If so, to what: _____

_____

Have you ever taken Bisphosphonates (Boniva, Fosamax, Didronel, Actonel) Yes __ No __

If so, which one: _____

Do you faint easily? Yes __ No __
Have you had any abnormal bleeding? Yes __ No __
Do you bruise easily? Yes __ No __
Do you use controlled substances? Yes __ No __
Do you use tobacco products? Yes __ No __ Type:_____ How much:_____

WOMEN:

Are you pregnant or think you may be pregnant? Yes ___ No __ Trimester? _____
Taking oral contraceptives? Yes __ No __
Nursing Yes __ No __

Circle the name of any of the following conditions, which you have had:

Stroke	Anemia
Heart surgery	Asthma
Heart attack	Shortness of Breath
Chest Pain/Angina	Emphysema
Irregular heart beat	Tuberculosis
Congenital heart disease	Thyroid problems
Replacement of heart valve	Fainting/Dizzy spells
Rheumatic heart disease/Fever	Diabetes
Swelling of hands, ankles or feet	Kidney trouble
High blood pressure	Joint Replacement
Low blood pressure	Epilepsy/Seizures
Hepatitis/Jaundice	Autoimmune disease
Cancer	Glaucoma
Radiation for Cancer	Drug Abuse
Chemotherapy for Cancer	None of these conditions

Do you have any condition, disease or problem not listed that you think should be known:

_____

Signature of patient, parent, or guardian: _____ Date _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services rendered on my behalf or my dependents.

Signature of patient, parent/guardian: _____ Date _____