**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: _____
Cell Ph#: _____ Home Ph#: _____
Address: _____
City, ST, Zip: _____

Employer: _____
Insur Co Name: _____ Insur. Ph#: _____

## 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 _____