MEDICAL/DENTAL HISTORY

Physician Name_____
Office Phone #_____ Date of Last Exam_____

Please list any medications, including non-prescription, that you are taking.

_____

_____

_____

Are you allergic to or have you had any reactions to the following? (check all that apply.)

Local Anesthetics____ Penicillin , other antibiotics____ Sulfa Drugs____ Sedatives____ Aspirin____ Metals____

Latex Rubber_____ Other (please list)_____

***Do you have or have you had any of the following*?** (check all that apply.)

Heart Problems____
Congenital Heart Defect____
Prosthetic Heart Valve____
Heart Palpitations____
Chest Pains____
Heart Murmur____
Heart Attack____
Cardiac Pacemaker____
Heart Disease____
Mitral Valve Prolapse____
Rheumatic Fever____
Bacterial Endocarditis____
High Blood Pressure____
Low Blood Pressure____
Stroke____

Respiratory Problems____
Easily Winded____
Asthma___
Emphysema/COPD____
Tuberculosis____
Kidney Problems____
Diabetes____
Liver Problems____
Hepatitis____
Jaundice____
Sexually Transmitted Disease ____
HIV/AIDS____
Anemia____
Bleeding Disorders____
Fainting____
Epilepsy____
Seizures____

Cancer____
Radiation Therapy____
Joint Replacement____
Digestive Problems____
Ulcers____
Acid Reflux____
Recent Weight Loss____
Frequently Tired____
Thyroid Problems____
Glaucoma____
Currently Pregnant____
Currently Nursing____
Other_____

_____

_____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? _____
If yes, please explain
_____

_____

Do you use or have you used any of the following? (check all that apply.)

Tobacco Products_____

Alcohol_____

Controlled substances, legal or Otherwise_____

Have you ever taken the following?
(check all that apply.)

Fen-Phen/Redux_____
Fosamax_____
Boniva_____
Actonel_____
Medications containing Bisphosphonates_____

Check here_____ if you are currently taking any blood thinning medications such as Coumadin, Plavix, Xarelto, etc.

I certify that I have read and understand the above information to the best of my knowledge. I have completed this form accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize Hilliard Modern Dental to release any information including the diagnosis and the records of treatment or examination rendered to me or my dependents during the period of such dental care to 3rd party payors &/or health practitioners. I authorize & request my insurance company to pay directly to Hilliard Modern Dental insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and my dependents.

Name (Printed)_____ Date_____

Signature_____