Medical History Update

Seven Springs DENTAL EXCELLENCE

Name _____ Date of Birth _____

Cell # _____ Home # _____ EMAIL _____

Emergency Contact _____ Phone # _____ Relationship to Patient _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If Yes, Explain _____

_____

Do you have any allergies to Medications/Antibiotics/Sulfa Drugs/Local Anesthetics/Seasonal/Latex? Please List _____

_____

Are you taking any medication(s) including non-prescription? Please List _____

_____

PAST OR CURRENT CONDITIONS: PLEASE CHECK YES OR NO

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure			Psychiatric Disorder			Joint Replacement			Pregnant		
Low Blood Pressure			Hemorrhagic Stroke			Revised Joint Replacement			Nursing		
Heart Issues/Disease			Liver Disease			Artificial Heart Valve			Stomach Problems		
Angina/Chest Pains			Hepatitis			Mitral Valve Prolapse			Ulcers		
Stroke			AIDS or HIV			Endocarditis			Gerd		
Heart Murmur			Blood Disease			Smoke/Chewing Tobacco			High Cholesterol		
Heart Attack			Excessive Bleeding			Emphysema			Thyroid Problem		
Pacemaker			Anemia			Respiratory Problems			Kidney Disease		
Diabetes			Jaundice			Asthma			Rheumatic Fever		
Epilepsy			Autistic			Arthritis			Organ Transplant		
Seizures			Cancer			Osteopenia			Sinus Problems		
Fainting			Radiation			Osteoporosis			Tuberculosis		
Swollen Ankles			Chemotherapy			Taken Bone Density Meds			Dry Mouth		

Please list any other illness or medical condition that is not listed: _____

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 than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ Date _____