

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ Are you pregnant?

If Yes, # of weeks

☐ ☐ Are you nursing?

Please answer the following:

Y N

☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only

BP

Heart Rate:

Weight:

Y N

Conditions

- ☐ ☐ Allergies
- ☐ ☐ Artificial Bones
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ High Blood Pressure
- ☐ ☐ HIV+ AIDS
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Pace Maker
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Botox/Dermal Fillers
- ☐ ☐ Alcohol Abuse
- ☐ ☐ Anemia
- ☐ ☐ Angina Pectoris
- ☐ ☐ Arthritis
- ☐ ☐ Asthma
- ☐ ☐ Cancer- Chemotherapy
- ☐ ☐ Colitis
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Diabetes
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Drug Abuse
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy

Y N

Conditions

- ☐ ☐ Fainting Spells
- ☐ ☐ Fever Blisters
- ☐ ☐ Frequent Headaches
- ☐ ☐ Glaucoma
- ☐ ☐ Hay Fever
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Surgery
- ☐ ☐ Hemophilia
- ☐ ☐ Hepatitis A
- ☐ ☐ Hepatitis B
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Radiation Therapy
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Seizures
- ☐ ☐ Shingles
- ☐ ☐ Sinus Problems
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis

Y N

Conditions

- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease
- ☐ ☐
- ☐ ☐
- ☐ ☐
- ☐ ☐

Y N

Allergies

- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Dental Anesthetics
- ☐ ☐ Erythromycin
- ☐ ☐ Jewelry
- ☐ ☐ Latex
- ☐ ☐ Metals
- ☐ ☐ Penicillin
- ☐ ☐ Tetracycline

Other

Medications:

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Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____ **Date:** _____
(If Under 18, Parent or Guardian Signature Required)

HINSDALE DENTISTRY

911 N. Elm, Suite 230

Hinsdale, IL 60521

630-323-4468

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

****You may refuse to sign this notice****

I acknowledge that I have received a written copy of this office's Notice of Privacy Practices.

Please Print Patient's Name

Patient's Signature (Parent's Signature if Patient is a Minor)

Date

AUTHORIZATION FOR LEAVING MESSAGES

I authorize Hinsdale Dentistry staff to leave a message on my home voice mail, answering machine or other electronic device, mobile phone or with a person who answers my home or mobile phone in regards to my appointment, pre medication, health, or my financial obligations to the practice.

Patient's Name

Patient's Signature (Parent's Signature if Patient is a Minor)

Date