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:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work 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?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Schieck Dental ~ Dr. Joel N. Schieck, D.D.S.

Name: _____ Date: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip: _____ Social Security#: _____

Phone: Home: _____ Cell: _____ Work: _____

Your Employer: _____ Language spoken at home: _____

☐ Male ☐ Female ☐ Minor Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Best time to reach you? _____ Person responsible for account: _____

Dental Insurance ☐ YES ☐ NO ~ Employer Providing Insurance: _____

EMERGENCY CONTACT: _____ PHONE # _____

How did you hear about our office: _____

Why have you come to the dentist today? _____

Have you ever had a serious problem with any previous dental work? Please explain: _____

_____

List Prescription Medications: _____

Previous Dentist: _____ Last dental visit: _____

Are you interested in learning about: ☐ **Teeth Whitening** ☐ **Botox®** (helping to remove frown lines) ☐ **Juvéderm®** (treatment for wrinkles) ☐ **Prevent Teeth Grinding** ☐ **Cosmetic Dentistry** (ex. White Fillings) ☐ **Headaches** ☐ **Facial Pain** ☐ **Jaw Joint Pain**

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment. I also authorize payment of insurance benefits to the doctor, unless I have paid my account in full. **I am responsible for any fees not covered by insurance, or for any co-payment, at the time services are rendered.** I have been offered a copy of this offices HIPAA (Health Insurance Portability and Accountabilities Act) policy to read and/or take with me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____ have read a copy of this office's Notice of Privacy Practices, also known as HIPAA. Relationship to patient named above: _____.

Signature _____ Initials _____ Date _____