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?

For Office Use Only
BP: Heart Rate:

Height:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	ADHD
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Alzheimer's Disease/Dementia
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Austism
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy

Y N	Conditions
☐ ☐	Fainting Spells
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	High Cholesterol
☐ ☐	HIV+ AIDS
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Osteoporosis
☐ ☐	Pace Maker
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures

Y N	Conditions
☐ ☐	Shingles
☐ ☐	Sinus Problems
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers

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

Other

_____

_____

_____

Medications:

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...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Dr. Joel N. Schieck, DDS **Date:**_____
Dr. Tucker C.B. Schieck, DDS

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security#:_____ **Language Spoken at Home:** _____

Phone: Home: _____ **Cell:** _____ **Work:** _____

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

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

Your Employer: _____

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** ☐**Snoring Reduction/Elimination**

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**_____