*Email*___________________________

HIGHLAND PARK ENDODONTICS

MEDICAL AND PERSONAL HISTORY

Last First MI Today's Date________________________

Name____Age_____Mr. Mrs Ms Dr

Address____Home Phone________________________ City, State, Zip____________Work Phone__________________

Sex: M F Patient SS#________________________Cell Phone_ May we text? Yes or No Date of Birth_ /_____/________Responsible Party_____________

Referring Dentist____________________ Employer____Current Position___________________

Dental Insurance Carrier_________________________________ Group #_________________________ Employer that Carries Benef_______________________

Medical History Circle all that applies, present and past **Date of Last Medical Exam ____________**

Heart Trouble	Lung Disease	Stroke	Hepatitis A	Asthma
High Blood Pressure	Tuberculosis	Anemia	Hepatitis B	Sinus Trouble
Heart Murmur	Kidney Trouble	Diabetes	Jaundice	Liver Disease
Heart Valve Problem	Allergy or Hives	Hemophilia	Epilepsy	Seizures
Drug Addiction	Mitral Valve Prolapse	Thyroid Disease	TMJ Pain	Rheumatic Fever
Blood Transfusion	Bleeding Problem	Latex Allergy	AIDS/ HIV+	Heart Pacemaker
Cortisone Therapy	Cancer/Leukemia	Chemotherapy	Artificial Joint	Venereal Disease

*** Do you have any disease or condition not listed? Yes No**

Please list____

*** Are you allergic to any medication or anesthetic injection? Yes No**

Please list medications and reaction____

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*** Do you routinely need antibiotics before dental treatment? Yes No**

Please list the name and amount of antibiotic you usually take________________________________

*** Are you under the care of a physician now? Yes No**

If yes, for what?____

*** If female, are you pregnant, breast-feeding, or taking oral contraceptives? Yes No**

* Please list ALL medications, vitamins, and supplements taken in the last 3 days, with dosages. (Include Aspirin, herbal supplements, oral contraceptives, etc.)

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Family Physician's Name ____ Phone #____________________

Preferred Pharmacy____ Phone #

Person to contact in case of emergency________________________________ Phone #____________________

I have answered these questions truthfully and accurately. Should subsequent visits occur I agree to inform my treating doctor of any changes in my health status, medication, address or phone numbers, or insurance information. I understand that failure to disclose medical and medication history may result in the immediate termination of doctor/patient relationship at the discretion of Highland Park Endodontics.

Patient Signature______________________________ *Date*__________________

*Doctor Initials*__________________

Revised 7-2013