

HODGES FAMILY & COSMETIC DENTISTRY

UPDATED PATIENT HEALTH HISTORY FORM

Today's Date: ____/____/____

Last Name	First Name	Middle Initial	SSN
Date of Birth	Sex	Height	Weight
Address		Zip Code	E-mail
Home Phone	Cell Phone	Work Phone	
Occupation	Place of Employment	Driver's License	
Spouse's Name	Spouse's Employer	Spouse's Work Phone	
Dental Insurance	Group #	Subscriber's Name	
Subscriber's Employer	Subscriber's Date of Birth	Subscriber's SSN	
Name of Physician	Physician's Phone		
Emergency Contact Name	Emergency Contact Phone		

MEDICAL HISTORY

Have you ever been treated for the following (please check all that apply)?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Prosthetic Heart Valve | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> T.B. | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |

Cancer/Chemotherapy – Type/Date _____

Radiation Treatment – Date _____

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cirrosis | |
| <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Leukemia | <input type="checkbox"/> History of Bleeding | |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Other _____ | |

Are you allergic to? Penicillin Codeine Aspirin Local injected anesthetics
 Latex Other _____

Are you pregnant? Yes No If yes, months? _____

Please list current medications, surgical procedures and/or hospitalizations (include dates and reason)

Have you taken or are you currently taking medications known as bisphosphonates (Zoledronic Acid-Zometa, Pamidronate-Aredia, Fosamax)? If yes, please explain. _____

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of dental and oral surgical procedures agreed to be necessary or advisable, including local anesthetic, as indicated. I will assume responsibility for fees associated with dental procedures I agree to.

Patient's Signature

Date