

# PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:  Today's Date:  Date of Last Visit:  Date of Med. History:

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City State Zip:

Email:

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Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

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Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Physician Name:

Physician Phone:

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Pharmacy:

Pharmacy Phone:

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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	Y N Conditions	Y N Conditions
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Human Papilloma Virus HPV	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Breathing Disorder	<input type="checkbox"/> <input type="checkbox"/> Joint Replacement	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Leukemia	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Pain In Jaw Joints	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Pregnancy	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS	<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Special Needs	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/>

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)

**FINANCIAL RESPONSIBILITY**

All professional services rendered are charged to the patient; the PATIENT is responsible for ALL fees the day the service is rendered.

If you have dental insurance, you are required to pay the estimated amounts in addition to any other co-insurance/deductibles required by your insurance company on the date of service. Upon completion of insurance payment, the unpaid balance is your responsibility to be paid in full; any overpayment will be refunded to you.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_, have had the opportunity to review a copy of this office's Notice of Privacy Practices and can receive a copy upon request.

I give the following family/friend(s) permission to access my health information.

\_\_\_\_\_  
\_\_\_\_\_

**Please review the following sections and initial the blanks provided.**

\_\_\_\_\_ I certify that I have read, answered, and understood all of the previous information on this form to the best of my knowledge. I understand that providing false information could possible be dangerous to my health or illegal in most cases.

\_\_\_\_\_ I consent to the performing of all procedures mutually decided upon between myself and the doctor to be necessary or in my best interest. If at any point I am uncertain of the risks or benefits of a procedure, I will ask.

\_\_\_\_\_ I consent to the disciosure of my health information to any other health care provider providing treatment.

**Consent to Release Medical Records**

I, \_\_\_\_\_, give my consent to release my medical records to Dr. John C. Osborn if needed for my dental treatment completion.

\_\_\_\_\_  
Patient (if over 18 years of age) OR Parent's signature

\_\_\_\_\_  
Date