Mount Auburn Dental

Medical History 2018

Who may we thank for referring you to our practice? _____

First Name _____ Last Name _____ MI ___ Date of Birth _____ SS# _____

Address _____ City/Town _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____ Best to Reach _____

Email Address: _____

Do you have any of the following drug allergies:

__Aspirin __ Latex __ Codeine __ Penicillin __ Anesthetic __ Antibiotics _Percodan __Erythromycin __ Sulfa

List any additional allergies: _____

Please check any that apply to you: **DO YOU REQUIRE PRE-MEDICATION BEFORE A VISIT? __ YES __ NO**

__ Heart Disease
__ Heart Surgery _____
__ Artificial Heart Valve
__ Mitral Valve Prolapse
__ Stroke
__ Pacemaker
__ HIV/AIDS
__ Other: _____

__ Artificial Joints
__ Cancer/Cancer Therapy
__ Tuberculosis
__ Kidney Disease
__ Liver Disease – Hepatitis
__ Epilepsy/Seizures
__ Mental Health Disorders

__ High Blood Pressure
__ Diabetes
__ Asthma
__ Drug Abuse/Addiction
__ Smoker – how many/D _____
__ Birth Control
__ Pregnancy/ Nursing

__ **NONE APPLY** Please use the back side of this form to elaborate on any checked conditions if needed.

List all medications you currently take, prescription and over-the-counter. (If you have a medication list we can photocopy it.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please provide the name and telephone number of an emergency contact should one be needed:

Name: _____

Relationship: _____

Phone: _____

Please indicate any of the following drugs you have taken at any time:

__ Fosamax __ Didronel __ Zometa __ Aredia

__ Skelid __ Bisphosphonates __ Actonel

Primary Physician _____

Specialist: _____

I certify the information recorded on this medical form is correct. I understand it is my responsibility to notify Mount Auburn Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Mount Auburn Dental or its employees liable in the event of injury or death.

_____ _____

Signature: (Patient/Guardian) Date