Mount Auburn Dental

Medical History 2020

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

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

_____ _____ _____
Address City/Town Zip Code

_____ _____ _____ _____
SS # Cell Phone Home Phone Best to Reach You

Email Address: _____ This will allow us to send you emails regarding appointment date/time

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
__ Stroke
__ Liver Disease – Hepatitis
__ Pacemaker
__ Other: _____
__ Artificial Joints
__ Cancer/Cancer Therapy
__ Tuberculosis
__ HIV/AIDS
__ Kidney Disease
__ Epilepsy/Seizures
__ High Blood Pressure
__ Diabetes
__ Asthma
__ Drug Use/Addiction
__ Smoker – how many/D _____
__ Birth Control
__ Pregnancy/ Nursing
__ Mental Health Disorders → Depression/anxiety/other (circle)_____

What Pharmacy do you use and where? _____

__ **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. **Please include dosages.**

(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