Hedgecock Dental, PLLC

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Medical History

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Indicate which of the following conditions you have or have history of. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response. This list continues onto the second page.

☐ Allergies, Drug	☐ Allergies, Other	☐ Anemia or Blood D/O	☐ Angina/Chest Pain
☐ Arthritis,Rheumatoid	☐ Arthritis	☐ Artificial Joints	☐ Artificial Valves
☐ Asthma	☐ Cancer, Tumor/Growth	☐ Cardiac Stent	☐ Cold Sores
☐ Currently Pregnant	☐ Diabetes	☐ Digestive Disorder	☐ Drug/Alcohol Use
☐ Duodenal Ulcer	☐ Emphysema	☐ Endocarditis	☐ Epilepsy or Seizures
☐ Fainting/Dizziness	☐ Glaucoma	☐ Head or Neck Injury	☐ Headaches/Migraines
☐ Heart Disease	☐ Heart Murmur	☐ Heart Surgery/Attack	☐ Hemophilia
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/Aids
☐ Hormone Deficiency	☐ Hypo/Hyperglycemia	☐ Immunosuppressives	☐ Implantable Defib.
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Lung Disease/Problem	☐ Lupus	☐ Measles, Chickenpox	☐ Mental Disorders
☐ Mitral Valve Prolaps	☐ Neurologic Disorders	☐ Osteo(porosis/penia)	☐ Other
☐ Pacemaker	☐ Para/Thyroid Disease	☐ Pre-Med for Dental	☐ Prolonged Bleeding
☐ Radiation or Chemo	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Sinus Problems
☐ Sleep D/O or Apnea	☐ Smoking/ Tobacco Use	☐ STI/STD	☐ Stomach Problems
☐ Stroke, Aneurysm	☐ TMJ, Jaw Pain	☐ Tuberculosis	☐ Weight Mgmt Meds

☐ FEMALE: Taking birth control ☐ FEMALE: Nursing

If you selected Drug/Alcohol Use please explain:

If you selected Allergies, Drug or Allergies, Other, please list any allergies:

If you selected Osteoporosis or Osteopenia, have you ever taken medication for this?

If you selected Other or if any conditions or alerts selected above need further clarification, please describe below:

If you take an antibiotic premedication for your dental visits, please explain:

List all medications (prescription and non-prescription) including regular doses of aspirin:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Name of your physician and phone number:

Name, location, and phone number of your preferred pharmacy:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Existing Patients - Please Verify and Update

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insurance Information on File

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____