Date:__________________
Cell Phone:________________
Home Phone:_______________

Dental Health History

Patient Name: ____Birthdate:______________
Home Address: _________________________ City_______________ State______ Zip__________
Email:____ SSN: __________________
Insurance: ___________________ Member ID:_____________________
Emergency Contact: ______________________ Phone number:_________________

Medical History

Physician's Name: _________________________________ Phone:_____________________

Have you ever had any serious illnesses or operations?______ If yes, what?______________When?____________

Have you ever had a blood transfusion? **Yes / No** If yes, when?____________________

Are you taking or *have you ever taken* bisphosphonates (Fosamax, Actonel, or Boniva for osteoporosis, or Aredia or Someta for multiple myeloma, or other cancers? **Yes / No** If yes, when?____________________

For women: Are you pregnant? **Yes / No** Nursing**? Yes / No**

Do you have any of the following?:

Anemia	**Y / N**	Cortisone Treatments	**Y / N**	Hepatitis	**Y / N**	Scarlet Fever	**Y / N**
Arthritis, Rheumatism	**Y / N**	Cough, Persistent	**Y / N**	Pacemaker	**Y / N**	High Blood Pressure	**Y / N**
Shortness of Breath	**Y / N**	Artificial Heart Valves	**Y / N**	Cough up Blood	**Y / N**	HIV/AIDS	**Y / N**
Skin Rash	**Y / N**	Artificial Joints	**Y / N**	Diabetes	**Y / N**	Jaw Pain	**Y / N**
Stroke	**Y / N**	Asthma	**Y / N**	Epilepsy	**Y / N**	Kidney Disease	**Y / N**
Back Problems	**Y / N**	Fainting Liver Disease	**Y / N**	Thyroid Problems	**Y / N**	Blood Disease	**Y / N**
Glaucoma	**Y / N**	Mitral Valve Prolapse	**Y / N**	Tobacco Habit	**Y / N**	Cancer	**Y / N**
Headaches	**Y / N**	Tonsillitis	**Y / N**	Heart Murmur	**Y / N**	Radiation Treatment	**Y / N**
Tuberculosis	**Y / N**	Chemotherapy	**Y / N**	Heart Problems	**Y / N**	Respiratory Disease	**Y / N**
Ulcer	**Y / N**	Circulatory Problems	**Y / N**	Hemophilia	**Y / N**	Rheumatic Fever	**Y / N**
Venereal Disease	**Y / N**	Swelling of Feet or Ankles	**Y / N**			Chemical Dependency	**Y / N**

List the medications you are currently taking:

Medication and dosage	Medication and dosage
1.	4.
2.	5.
3.	6.

Pharmacy Name:__________________________________ Pharmacy Phone number:____________________

Allergies:

Aspirin	**Y / N**	Penicillin	**Y / N**	Codeine	**Y / N**
Barbiturates (Sleeping pills)	**Y / N**	Local Anesthetic	**Y / N**	Sulfa	**Y / N**
Latex	**Y / N**	Other:______________________________			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I will notify the office immediately of any changes in my health status or the above information. I also understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

Signature:____ **Date:**________________

DEERFIELD DENTAL SERVICES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for *Deerfield Dental Services* this ___ day of ____, 20___. A copy of this signed, date Acknowledgement shall be as effective as the original.

____

Please print your name

____

Please sign your name

If you are the legal representative of the patient, please print the patient's name and describe your authority __________________________________.

<u>Office Use Only</u>

It was emergency Treatment _______

I could not communicate with the patient _______

The patient refused to sign _______

The patient was unable to sign because (please describe)

____

____

Signature of privacy official