Dr. Gregory A. Hillyard & Dr. Alexandra H. Monroe

PATIENT HEALTH HISTORY UPDATE

Please PRINT all information. Thank you.

Name _____ Mr. Mrs. Dr. Miss Ms. Date of Birth _____

Address_____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell _____

Occupation _____ Employer_____Work Phone_____

Physician's Name _____ Physician's # _____

Emergency Contact _____ Relation_____ Phone _____

Marital Status_____ Name of parent/guardian if patient is a minor:_____

Preferred Method for Appointment Reminders: ☐ Text ☐ Email ☐ Home ☐ Cell

Do you have Dental Insurance? ☐ Y ☐ N Name of Insurer: _____

If you would like us to submit claims on your behalf, please provide either your dental Insurance ID number _____
or your social security number. _____

1. Are you happy with your smile? ☐ Y ☐ N If not, why? _____

2.. Please list any MEDICATIONS or SUPPLEMENTS you are currently taking: _____

_____

3. Do you smoke? ☐ Y ☐ N Previously smoked? ☐ Y ☐ N If yes to either, for how long?_____

4. Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other Please explain:_____

Please list all other allergies (food, drug, environmental, etc.)

WOMEN

Are you pregnant or trying to get pregnant? ☐ Y ☐ N Taking oral contraceptives? ☐ Y ☐ N Nursing? ☐ Y ☐ N

Please indicate with an X in the box if you have, or have not had,any of the following medical conditions.

YES	NO		YES	NO		YES	NO		YES	NO	
		AIDS/HIV Positive			Congenital Heart Defect			Hemophilia			Pain in Jaw Joints
		Alzheimer's Disease			Diabetes			Hepatitis			Psychiatric Care
		Anemia			Drug addiction			Herpes			Radiation Treatments
		Anorexia			Dry Mouth			High Blood Pressure			Recent Weight Loss
		Arthritis			Epilepsy or Seizures			High Cholesterol			Renal Disease
		Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Sickle Cell Disease
		Artificial Joint			Excessive Thirst			Hypoglycemia			Sinus Trouble
		Asthma			Fainting/Dizziness			Irregular Heartbeat			Spina Bifida
		Breathing Problem			GERD			Kidney Problems			Stomach Trouble
		Bruise Easily			Glaucoma			Leukemia			Stroke
		Bulimia			Headaches			Liver Disease			Swelling of Limbs/Feet
		Cancer			Heart Attack/Failure			Low Blood Pressure			Thyroid Disease
		Chemotherapy			Heart Murmur			Lung Disease			Tonsillitis
		Chest Pains			Heart Pacemaker			Mitral Valve Prolapse			Tumors or Growths
		Cold Sores			Heart Trouble/Disease			Osteoporosis			Ulcers

Have you ever had any serious illness not listed above? ☐ Y ☐ N Please explain: _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____