HERITAGE HILL DENTAL

Patient Name_____ Date of Birth _____

Primary Care Physician's Name: _____ Date of Last Visit: _____

**Are you currently taking or have you ever taken a Bone Health Medication?:◯Fosamax◯Boniva◯Actonel◯Other◯None**

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Bleeding | ◯ Yes ◯ No | Epilepsy | ◯ Yes ◯ No | Radiation | ◯ Yes ◯ No |
| Acid Reflux | ◯ Yes ◯ No | Glaucoma | ◯ Yes ◯ No | Respiratory Disease | ◯ Yes ◯ No |
| Aids/HIV | ◯ Yes ◯ No | Headaches | ◯ Yes ◯ No | Shortness of Breath | ◯ Yes ◯ No |
| Angina | ◯ Yes ◯ No | Heart Problems | ◯ Yes ◯ No | Sinus Trouble | ◯ Yes ◯ No |
| Artificial Heart Valves | ◯ Yes ◯ No | Hepatitis : Type_____ | ◯ Yes ◯ No | Skin Rash | ◯ Yes ◯ No |
| Artificial joints | ◯ Yes ◯ No | Herpes | ◯ Yes ◯ No | Stroke | ◯ Yes ◯ No |
| Asthma | ◯ Yes ◯ No | High Blood Pressure | ◯ Yes ◯ No | Swollen Feet/Ankles | ◯ Yes ◯ No |
| Blood Disease | ◯ Yes ◯ No | Kidney Disease | ◯ Yes ◯ No | Swollen Neck Glands | ◯ Yes ◯ No |
| Cancer | ◯ Yes ◯ No | Liver Disease | ◯ Yes ◯ No | Thyroid Problems | ◯ Yes ◯ No |
| Chemical Dependency | ◯ Yes ◯ No | Low Blood Pressure | ◯ Yes ◯ No | Tobacco Use | ◯ Yes ◯ No |
| Chemo | ◯ Yes ◯ No | Marijuana Use | ◯ Yes ◯ No | Tuberculosis | ◯ Yes ◯ No |
| Comprimised Immunity | ◯ Yes ◯ No | Mental Illness | ◯ Yes ◯ No | Ulcer | ◯ Yes ◯ No |
| Congenital Heart Lesions | ◯ Yes ◯ No | Mitral Valve Prolapse | ◯ Yes ◯ No | Unexplained Weight Loss | ◯ Yes ◯ No |
| Cortisone Treatments | ◯ Yes ◯ No | Organ Transplant | ◯ Yes ◯ No | Vape Use | ◯ Yes ◯ No |
| Cough, Persistant or Bloody | ◯ Yes ◯ No | Osteoporosis | ◯ Yes ◯ No | Other:_____ | |
| Currently Pregnant: Due _____ | ◯ Yes ◯ No | Pacemaker | ◯ Yes ◯ No | | |
| Diabetes -Type_____ | ◯ Yes ◯ No | Previous Infective Endocaditis | ◯ Yes ◯ No | | |

**PRE-MEDICATION**

Have you been told that you are required to take and antibiotic prior to dental treatm

Prescribing doctor's name: _____

Prescribing doctor's phone #: _____

Antibiotic Rx: _____

**ALLERGIES**

| Aspirin | Codeine | Latex | Local Anesthetic | Penicillin | Sulfa | None | Other *(specify)* |
|---|---|---|---|---|---|---|---|
| ○◯ | ○◯ | ○◯ | ○◯ | ○◯ | ○◯ | ○◯ | |

**PATIENT AUTHORIZATION**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Heritage Hill Dental of any changes in my medical status. I authorize the dental staff to perform necessary dental services that I may need during diagnosis and treatment.

Sign_____