

**CONFIDENTIAL MEDICAL HISTORY**

\*\*\*PLEASE PRINT CLEARLY\*\*\*

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Referred By \_\_\_\_\_

**DENTAL INSURANCE INFORMATION** (please let us know if you have DENTAL insurance and we would be more than happy to file your claim for reimbursement back to you)

Policyholder Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ SS Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Dental Insurance \_\_\_\_\_ (attach your insurance card to the clipboard)

Previous Hospitalizations When \_\_\_\_\_ What for \_\_\_\_\_ .List others at bottom of page.

Directions: Circle all that applies. If you are not sure, put a question mark.

<b>GENERAL ALERTS</b>	<b>CONDITIONS</b>	<b>CONDITIONS</b>	<b>ALLERGIES</b>	<b>MEDICATIONS</b>	<b>LIST MEDS.</b>
Allergy to Meds	Current Med Trt	Ulcers/Digestive	Penicillin	No Medications	_____
Health Problem	Heart Condition	Migraine/Headaches	Antibiotics	Antibiotics	_____
Medications	High Blood Pressure	Epilepsy/Fainting	Aspirin	Pain Medication	_____
Very Apprehensive	Respiratory/Asthma	Glaucoma/Visual	Tylenol	Heart Medicine	_____
Pregnant	Rheumatic Fever	Mental/Neural	Codeine	Aspirin	_____
Seasonal Allergies	Hypertension/Circula	Tumor/Neoplasms	Narcotics	Cortisone/Steroid	_____
	Immumocompromised	Alcoholism/Addiction	Local Anesth	Blood Thinner	_____
	Anemia/Bleeding	Infectious Diseases	Latex	Blood Pressure	_____
	Diabetes/Kidney	Venereal Diseases	Sulfa		
	Herpes	Hepatitis			
	Thyroid/Hormonal				

Adverse reactions to General anesthesia When/What kind. \_\_\_\_\_.

PLEASE NOTE: The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal law establishing standards for the privacy and security of health information. We make every effort to protect the security and confidentiality of your health information. I have received a NOTICE OF PRIVACY PRACTICES and I do hereby give my permission to J. Christian Sheaffer, DDS, PLLC regarding the release of information needed to complete my treatment. Please initial \_\_\_\_\_

**\*\*ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE\*\***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_