CONFIDENTIAL MEDICAL HISTORY ***PLEASE PRINT CLEARLY***

Patient Name_____
Address _____**City**_____**State**_____**ZipCode**_____
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.

GENERAL ALERTS	CONDITIONS	CONDITIONS	ALLERGIES	MEDICATIONS	LIST MEDS.
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: _____**