Patient Name:_____
Date Of Birth:_____
Today's Date: _____

Welcome Back to Babcock Dental Center

In order to help us serve your dental needs, we need to obtain and keep an up-to-date and thorough health history. Please complete this form to the best of your knowledge and write down any changes, additions, or subtractions in medical conditions, medications (including supplements), and any allergies you have. Thank you!

If any changes have occurred to the following, please list below. Otherwise, <u>you may skip this section.</u>

Address: _____ Home Phone: _____ Cell Phone: _____	Insurance Co: _____ Insurance Subscriber: _____ Subscriber Soc. Sec. #: _____ Subscriber Birthdate: _____ Group #: _____	Emergency Contact Name: _____ Relationship: _____ Phone Number: _____	Physician Name: _____ Are you being seen by any specialist physicians? List: _____

<u>Medical History:</u>

Please list any prescription or non-prescription medications that you are currently taking. <u>Do not leave any medications unreported</u>.

Medications: _____

_____

▢ Are you pregnant or think you may be pregnant? ▢ Are you nursing? ▢ Are you taking Birth Control Pills?	▢ Are you under any current medical treatment? ▢ Do you currently smoke? ▢ Do you use chewing tobacco or snuff? ▢ Do you take aspirin or blood thinners?	▢ Are you allergic to Penicillin? ▢ Do you have allergies to any other medications? Please List: _____ _____
▢ Respiratory Problems ▢ Asthma ▢ Emphysema ▢ Seasonal Allergies ▢ Sleep Apnea ▢ COPD or Emphysema	▢ High Blood Pressure ▢ Heart Disease ▢ Heart Attack ▢ Heart Murmur ▢ Mitral Valve Prolapse ▢ Angina/Chest Pain ▢ History of Stroke ▢ Heart Valve Replacement ▢ Cardiac Pacemaker	▢ Fainting ▢ Epilepsy/Seizures ▢ Autoimmune Disease ▢ Glaucoma ▢ Thyroid Problem (Indicate) ▢ Alzheimers/Dementia ▢ Hearing Impaired ▢ Blindness
▢ Leukemia ▢ Anemia ▢ Stroke	▢ Tuberculosis ▢ Sexually Transmitted Infection ▢ HIV or AIDS	▢ Anxiety ▢ Depression ▢ Substance Use Disorder
▢ Cancer (Indicate type) ▢ Radiation Therapy ▢ Chemotherapy ★ Have you ever been given the chemotherapy drug Zometa?	▢ Liver Disease ▢ Hepatitis/Jaundice ▢ Kidney Disease ▢ Diabetes (Indicate Type 1 or Type 2) ▢ Stomach Ulcers ▢ Stomach Problems ▢ GERD	▢ Arthritis ▢ Prior bisphosphonate use ▢ Joint Replacement ★ Has your orthopedic surgeon ever advised you to take antibiotics before dental treatment?

The most important purpose of this form is to update your health history in our records. Please, if there are any additional medical conditions, medications, or allergies that have developed since your last visit at Babcock Dental Center, list below:

_____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

Patient, Parent or Guardian — Date