Medical History

LAST NAME	FIRST NAME	PREFERRED NAME	MI	TODAY'S DATE

MAILING ADDRESS	CITY	STATE	ZIP CODE	GENDER
				Male Female Other

PHONE NUMBERS			E-MAIL ADDRESS (print clearly)
Home:	Work:	Cell:	

SOCIAL SECURITY NUMBER	DATE OF BIRTH	STATUS
		Married Divorced Widowed Single Child

Please <u>circle</u> ALL that apply **if you are experiencing symptoms or have a condition you are being treated for medically:**

<u>Artificial Heart Valve</u>	**Bleeding Abnormally**	**GAGS Easily**	**Radiation**
<u>Artificial Joints or Limbs</u>	**Back Problems**	**Gerd (Acid Reflux)**	**Seizures Past/Present**
<u>(AFib) Atrial Fibrillation</u>	**Blood Disease**	**Glaucoma**	**STD'S**
Past / Present	**Circulatory Problems**	**Heart Pacemaker**	**Stroke - Date:_____**
<u>Blood Thinner Medication</u>	**Congenital Heart Lesions**	**Hepatitis /Type:_____**	**Spleenectomy - Date: _____**
<u>Cancer/ Chemo</u> Past / Present	**Contact Lenses**	**Herbal + Dietary Supplement**	**Swollen Neck/Glands**
<u>Diabetes</u> Type: I or II	**Cortisone Treatments**	**High Cholesterol**	**Stents**
<u>Heart Attack</u> Date:_____	**Cough (bloody or**	**Hyperactive**	**Thyroid Problems**
<u>Heart Disease/Angina</u>	**persistent)**	**Hypoglycemia**	**Tobacco products/E-Cigarettes**
<u>High Blood Pressure</u>	**Deaf/hard of hearing**	**Jaundice**	**Past / Present**
Past / Present	**Dizziness if reclined**	**Jaw Pain**	**Tonsillitis**
<u>Osteoporosis</u>	**Drug Dependent**	**Kidney Disease**	**Tuberculosis**
AIDS/HIV	**Dry mouth**	**Liver Disease**	**Tumors**
Alcohol Dependent	**Emphysema**	**Low Blood Pressure**	**Ulcers**
Anemia	**Epilepsy**	**Medical Marijuana**	**Weight Loss, unexplained**
Anxiety	**Eye Surgery**	**Pregnant**	**Other:_____**
Arthritis	**Headaches**	**Psychiatric Care**	**_____**
Asthma/Breathing problems			**_____**
Past / Present			

Do you have any <u>ALLERGIES?</u> (Please circle): Aspirin Codeine Demerol Latex Metal Penicillin Sulfa

Tetracycline Local Anesthesia Other (dust, pollen, animals etc.): _____

Have you ever had any complications following dental treatment?	**YES**	**NO**
Have you been admitted to the hospital or needed emergency care in the past two years?	**YES**	**NO**
Are you under regular medical care from a physician <u>for a condition</u>?	**YES**	**NO**
Have you ever been involved in an act of abuse?	**YES**	**NO**
Do you have a prosthetic cardiac valve?	**YES**	**NO**
Have you had previous bouts of infective endocarditis?	**YES**	**NO**
Do you have any congenital heart diseases?	**YES**	**NO**
Are you a cardiac transplant recipient who developed valvulitis?	**YES**	**NO**

When provided, do you wish to receive <u>TEXT MESSAGE APPOINTMENT REMINDERS?</u> YES NO

When provided, do you wish to receive <u>E-MAIL APPOINTMENT REMINDERS?</u> YES NO

MaineDental
Rachel Taddeo D.M.D., M.A.

Please list all medications, supplements and herbs you are currently taking and the reason for taking them:

NAME	REASON FOR TAKING

Are you currently taking any of the following? *(Check YES or NO)*

Medical Marijuana YES ____NO _____

Pre-Medication (due to heart condition and taken 1 hour prior to dental appointments) YES _____ NO_____

MAO Inhibitors (MAOIs have been found to be of most use in treating atypical depression, which is characterized by overeating, sleeping too much, sensitivity to rejection, leaden paralysis and strong reactions to environment.)YES____ NO_____

Birth Control Pills YES _____ NO _____

Anticoagulants (Blood Thinner Medication)
YES ____ NO_____(Aspirin, Heparin, Coumadin, Plavix, etc…)

Bisphosphonates (Bone Density Medication)
YES____ NO_____(Boniva, Fosamax, Actonel, etc.)

Tobacco use:
Never _____
Current smoker: Packs/Day_____
Number of years: _____
Tobacco: Cigarette _____Pipe_____ Cigar_____ Snuff _____ Chew _____
Are you interested in quitting? YES NO_____
Alcohol Use: Do you drink alcohol? YES _____ NO _____ Number of drinks/week_____
Do you have a history of previous drug addiction? YES ____ NO_____

Previous Dental experience:
When was the last time you visited a dentist? DATE_____
Do you have anxiety when visiting a dentist? YES _____ NO_____
Is there anything we can do to make your visit more comfortable?_____

To the best of my knowledge, all of the preceding information provided is true and correct. If I have any change in my health, I will inform the doctors at the next appointment without fail. I am also aware that MaineDental participates with the HIPAA privacy act, ensuring me that they take all reasonable precautions, making sure my personal information remains private. Per your request, we will provide you with a copy of our notice of privacy practices.

I hereby authorize MaineDental. to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to MaineDental. I understand I am responsible for any unpaid balances. For those with no insurance, I acknowledge that payment in full is expected of me at the time service is rendered.

Signature | Print patient/guardian name | Date