Medical History

LAST NAME	FIRST NAME	PREFERRED NAME	MI	TODAY'S DATE

MAILING ADDRESS	CITY	STATE	ZIP CODE	GENDER
				Male Female

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

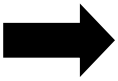
Do you have any <u>ALLERGIES?</u> (Please circle): Aspirin Codeine Demerol Latex Metal Penicillin Sulfa

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



EVERGREEN DENTAL ASSOCIATES, LLC

281 Western Avenue • Augusta • Maine • 04330 • (207) 622-0861

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

NAME	REASON FOR TAKING

Are you currently taking any of the following? *(Circle those that apply)*

<u>Medical Marijuana</u>

<u>Pre-Medication</u> (due to heart condition and taken 1 hour prior to dental appointments)

<u>MAO Inhibitors</u> (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.)

<u>Birth Control Pills</u> Past Present

<u>Anticoagulants (Blood Thinner Medication)</u>
(Aspirin, Heparin, Coumadin, Plavix, etc…)

<u>Bisphosphonates (Bone Density Medication)</u>
(Boniva, Fosamax, Actonel, etc…)

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 Evergreen Dental Associates participates with <u>the HIPAA privacy act</u>, 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 Heather S. Harper, D.D.S., Peter R. Shumway, D.M.D. and Maegan E. Beinoras, D.D.S. to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Heather S. Harper, D.D.S., Peter R. Shumway, D.M.D. or Maegan E. Beinoras, D.D.S. 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