PATIENT MEDICAL HISTORY / HIPAA CONSENT

PATIENT NAME ____

*Please list your **Primary Care Physician's** information in case of emergency. Feel free to use our phonebook.*
DOCTOR'S NAME ____ PHONE # __________________________
ADDRESS _____________________________________ CITY ________________ STATE ____ ZIP __________
Have you been under the care of a medical doctor for anything unusual during the past two years? ___YES ___NO
If yes, for what?____
Are you currently taking any medications or drugs, including regular doses of aspirin or over-the-counter herbal medications? ___YES ___ NO
If yes, please list name and dosage (use back of page if necessary) ______________________________________
____

Are you aware of having an allergic reaction to any medication or substances? ___ YES ___ NO
If yes, please list (use back of page if necessary) ____

Have you been a patient in the hospital during the past 5 years? ___ YES ___ NO
Who may we contact in case of emergency? ____________________________ PHONE ____________________

PLEASE CIRCLE WHICH OF THE FOLLOWING THE PATIENT HAS, OR HAS HAD IN THE PAST

Heart Disease	Y N	Diabetes	Y N	Hepatitis A B C (circle)	Y N
Thyroid Problems	Y N	Chest Pains	Y N	Veneral Disease	Y N
Glaucoma	Y N	Ulcers	Y N	A.I.D.S.	Y N
Contact Lenses	Y N	Chronic Cough	Y N	H.I.V.	Y N
Cancer	Y N	Emphysema	Y N	Cold Sores/Fever Blisters	Y N
Chemotherapy	Y N	Tuberculosis	Y N	Blood Transfusion	Y N
Latex Allergy	Y N	Hay Fever	Y N	Hemophilia	Y N
Sinus Troubles	Y N	Allergies/Hives	Y N	Sickle Cell Disease	Y N
Heart Murmur	Y N	Asthma	Y N	Bruise Easily	Y N
High Blood Pressure	Y N	Liver Disease	Y N	Nervous/Anxious	Y N
Mitral Valve Prolapse	Y N	Kidney Trouble	Y N	Cortisone Medicine	Y N
Artificial Heart Valve	Y N	Artificial Joints	Y N	Stroke	Y N
Swollen Ankles	Y N	Psychiatric Care	Y N	Neurological Disorders	Y N
Heart Pacemaker	Y N	Yellow Jaundice	Y N	Epilepsy or Seizures	Y N
Rheumatic Fever	Y N	Radiation Therapy	Y N	Fainting/Dizzy Spells	Y N
Arthritis/Rheumatism	Y N				

List any disease or condition not mentioned above ____
Women: Are you pregnant _______ Nursing? ______ Taking Birth Control Pills? ______
I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and will notify the dentist/office of any changes in my health or medication. Furthermore, in accordance with HIPAA Privacy Policy, I hereby give consent to Dr. Gary L. Riddle and all other dental care providers used for referring to use and disclose my protected health information for the purpose of treatment, payment, and health care operations.

Cancellation fees may be charged for missed appointments if appropriate notice is not given.

Patient/Guardian Signature ____ DATE ____________________

Please review ANNUALLY, revise if any changes in your health history have occurred, and sign below.
Patient/Guardian Signature ____ DATE ____________________
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Patient/Guardian Signature ____ DATE ____________________
Patient/Guardian Signature ____ DATE ____________________