MEDICAL HISTORY UPDATE

MID-VALLEY DENTAL ASSOCIATES
Taylor C. Bennion, DMD

Name: _____

Physicians Name: _____ Date of last physical: _____

Have you had any serious illness or operations? yes____ no ____ If yes, describe: _____

For female patients only:
Are you pregnant? yes____ no ____ Nursing? yes____ no ____ Taking birth control pills? yes____ no ____

Do you require antibiotics prior to dental treatment? yes____ no ____

Please check if you have or have had any of the following:

- ☐ AIDS
- ☐ Alzheimers, Dementia, memory loss
- ☐ Anemia
- ☐ Artificial joints
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Other (describe):
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Kidney disease
- ☐ Latex allergy
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Shortness or breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

MEDICATIONS: _____

_____

ALLERGIES:_____

_____

Are there any changes to your contact or insurance information? yes____ no ____ ***If yes, please fill out the sections below.***

CONTACT INFORMATION:

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile: _____ Work: _____

Email: _____

INSURANCE INFORMATION:

Primary insurance carrier: _____ Subscriber ID No: _____ Group No:_____

Secondary insurance carrier: _____ Subscriber ID No: _____ Group No:_____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____ Phone: _____

By signing, I acknowledge that I have read and answered the above questions to the best of my knowledge.

_____ _____
Signature of patient (or of parent or guardian if patient is a minor) Date

2811 Main Street, Philomath, OR 97370 | (541) 929-5227