Idaho Falls Dental Group Patient Health History Update

Thank you in advance for keeping us informed of your medical history. We've tried to keep this update as brief as possible. This information greatly helps us administer safe dental procedures.

Patients Name _____Date of Birth_____/_____/_____

Mailing Address _____ City_____ State _____ Zip _____

Home Phone _____Cell Phone _____

Social Security Number (for ins. purposes only): _____ Email Address_____

Preferred Pharmacy: _____ Emergency Contact (Name/ #): _____

• Are you currently under medical treatment?
Condition: _____ Physician: _____ Yes/No

• Have you had any serious illness or operations?
_____ Yes/No

• Any chronic medical conditions? (i.e. diabetes, osteoporosis, arthritis, etc.)
_____ Yes/No

• Are you currently taking medication(s)? List:
_____ Yes/No

• List allergies to local anesthetics, antibiotics, sulfa, latex, or other medications?
_____ Yes/No

• Are you taking blood thinners? List:
_____ Yes/No

• Do you have artificial heart valve, congenital heart disease, or a joint prosthesis? …….....Yes/No

• Have you been told to pre-medicate prior to dental treatment? ……..…….....Yes/No

• Are you taking or have you taken medication for osteoporosis or cancer? …….....Yes/No

• Women: Are you pregnant, nursing, or taking birth control pills? …….....Yes/No

Please circle all that apply, past or present:
Diseases: AIDS, venereal disease, hepatitis, tuberculosis, any communicable disease, cancer/tumor/chemotherapy, heart disease, liver disease, kidney disease, respiratory problems, stroke, epilepsy or seizures, thyroid disease, blood disease, diabetes, psychiatric care, chemical dependency, chronic fatigue syndrome, ulcer or digestive system problems.

Symptoms and treatment of diseases: Abnormal bleeding, high blood pressure, low blood pressure, artificial heart valve, artificial joint(s), circulatory problems, cortisone treatments, chronic fainting and dizziness, glaucoma, headaches, HIV positive, jaundice, jaw pain, pacemaker, radiation treatment, shortness of breath, sinus trouble, serious allergies.

Assignment and Release
I hereby authorize payment directly to the Idaho Falls Dental Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

3830 S 25th E St Idaho Falls, Idaho 83404
(208) 525-8383 **www.ifdentalgroup.com**

Please Complete Reverse Side

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I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I certify that the above information is true.

_____	_____	_____
(Please Print Name of Responsible Party)	(Signature)	(Date)

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