Health History Update

Thank you in advance for taking the extra time to inform our team of any changes to your health. we appreciate your effort.

Elizabeth Mattson, DDS
uptown family dental

Patient Name: _____ Date: _____

Address Changes? Yes/No _____

Insurance Changes? Yes /No **If so please let us know:*

Insurance Company _____ Group# _____

Subscriber_____ Subscriber DOB: _____

Subscriber ID# _____ Employer: _____

Do you have or have you had any of the following?

Please Check all boxes that apply

- ☐ Recent Surgery or Have you been hospitalized during the past 5 years?_____
- ☐ Cancer or Tumor/Radiation treatment
- ☐ Heart ailment or Angina
- ☐ Pacemaker, Heart Murmur, Mitral Valve Prolapse, or Heart Defect
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Artificial Joint or Valve ***(Hip, Knee, Ankle, Shoulder, etc.)***
- ☐ High or Low Blood Pressure
- ☐ Tuberculosis, Emphysema, or Other Lung Problems
- ☐ Kidney Disease
- ☐ Hepatitis B, C, or Other Liver Disease
- ☐ Alcoholism
- ☐ Blood Transfusion
- ☐ Diabetes
- ☐ Neurologic Condition
- ☐ Epilepsy, Seizures, or Fainting Spells
- ☐ Emotional Condition
- ☐ Arthritis
- ☐ Herpes or Cold Sores
- ☐ AIDS or HIV+
- ☐ Migraine Headaches, or Frequent Headaches
- ☐ Anemia or Blood Disorders
- ☐ Abnormal Bleeding after extractions, surgery, or trauma
- ☐ Hay fever or Sinus Problems
- ☐ Allergies or Hives
- ☐ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex
- ☐ Penicillin or other Antibiotics **if so, please list:* _____
- ☐ Local Anesthetics ("Novocain")
- ☐ Codeine or other Narcotics
- ☐ Sulfa Drugs
- ☐ Barbiturates, Sedatives, or Sleeping Pills
- ☐ Aspirin
- ☐ Other: _____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (Blood Thinners)
- ☐ Antibiotic or Sulfa Drugs
- ☐ High Blood Pressure Medications
- ☐ Antidepressants or Tranquilizers
- ☐ Insulin, Orinase, or Other Diabetic Drug
- ☐ Nitroglycerin
- ☐ Cortisone or Other Steroids
- ☐ Osteoporosis (Bone Density) Medicine
- ☐ Other: _____

For Women:

- ☐ May be Pregnant, or Pregnant: Expected Delivery Date: _____
- ☐ Taking Hormones or Contraceptives

Please list all medications: _____

_____

Name of Physician: _____ **Telephone:**_____

Last Exam Date: _____

Do you have any disease, condition, or problem not listed above? _____

Acknowledge and Authority

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be issued by attending doctor or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, **at the time of service** unless other prior arrangements are made. **We require 48 hour notice to avoid cancellation fees if unable to keep a scheduled appointment time.** Medical and Dental records are kept confidential in accordance with HIPAA guidelines in this practice.

_____ _____

Signature of Patient (or Guardian if under 18) Date