9411 Avenue Ste P
El Paso, TX. 79907
Phone: 915 858 6868

MEDICAL HEALTH HISTORY

Patient's Name _____
Resp. Party's Name _____
Patient's Address _____
City _____ State _____ Zip _____
Hm# _____ Wk# _____
Cell/Pager/Emergency # _____
Patient's birthdate _____
Sex: Female _____ Male _____
Referred to our office by: ❑ Friend _____
❑ Doctor _____ ❑ Yellow Pages ❑ Hispanic Phone Book ❑ Bilboard ❑ Other _____

Patient's Employer _____
Resp. Party's Employer _____
Employer's Address _____
Patient's Social Security # _____
Ins. Carrier Name _____
Benefit # _____
Group # _____
AHCCCS Plan Name _____

			DOCTORS NOTES
1.	Are you under a physician's care? Physician's Name _____ Phone # _____ Why _____		← IMPORTANT
2.	When was your last complete physical exam? _____		
3.	Are you taking any medications or substances? _____	Yes No	
4.	Are you allergic to any medication or substances? _____	Yes No	
5.	Do you have any problems with penicillin, antibiotics, local anesthetics (Novocaine) or other types of medication? _____	Yes No	
6.	Do you have any other allergies? _____	Yes No	
7.	Are you sensitive to any metals or latex? _____	Yes No	
8.	Are you pregnant or suspect you are? _____	Yes No	
9.	Do you take birth control medications? _____	Yes No	
10.	Have you ever been treated for heart disease? _____	Yes No	← IMPORTANT
11.	Do you have a pacemaker or an artificial heart valve implant? _____	Yes No	
12.	Have you ever had rheumatic fever? _____	Yes No	
13.	Are you aware of having a heart murmur? _____	Yes No	
14.	Do you have high/blood pressure? _____	Yes No	
15.	Have you ever had any major illness or surgery? _____	Yes No	
16.	Have you ever had seizures or convulsions? _____	Yes No	
17.	Have you ever had radiation treatment, chemotherapy, or any other? _____	Yes No	
18.	Do you have soreness, clicking, or popping in your jaw joint? _____	Yes No	
19.	Do you have any blood disorders, such as anemia, leukemia, hemophilia, etc? _____	Yes No	
20.	Do you have any artificial joints/prosthesis? _____	Yes No	
21.	Have you ever bled excessively after being cut or injured? _____	Yes No	
22.	Have you ever received a blood transfusion? _____	Yes No	← IMPORTANT
23.	Do you have kidney, stomach or liver problems? _____	Yes No	
24.	Are you diabetic? _____	Yes No	
25.	Do you have asthma? _____	Yes No	
26.	Are you HIV positive? _____	Yes No	
27.	Do you have AIDS? _____	Yes No	
28.	Have you had or do you test positive for Hepatitis? _____	Yes No	
29.	Do you or have you had tuberculosis? _____	Yes No	
30.	Do you smoke, chew, use snuff or any other forms of tobacco? _____	Yes No	
31.	Do you consume alcoholic beverages? _____	Yes No	← IMPORTANT
32.	Is there anything else we should know about your health that we have not covered in this form? _____	Yes No	

I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medication necessary for dental treatment.

The parent or guardian is required to remain in the Waiting Area during their child's dental treatment !!!

Patient's (Guardian) Signature _____ Date _____ Reviewed By _____
First Visit
Patient's (Parent) Signature _____ Date _____ Reviewed By _____
Second Update
Any changes: _____