Yearly Medical History Update

Patient Information

First Name *	Last Name *	Date of Birth *	Age *
		/ /	

Gender ⚪ Male ⚪ Female ⚪ Unknown

Address *	City *	State *	Zip *

Home Phone *	Cell Phone *	Work Phone *	Ext *
(____) _____ - _____	(____) _____ - _____	(____) _____ - _____	_____

Preferred Method of Contact? ⚪ Phone ⚪ Text/SMS ⚪ Email

Has your insurance changed? ⚪ YES ⚪ NO ⚪ CASHPAY
If 'Yes', please present the card at check-in or email your card (front & back) to info@phillippidental.com.

Name of Primary Physician:	Physician Phone Number
	(_____) _____-_____

Within the past year, have there been any changes in your general health?
⚪ YES ⚪ NO

WOMEN ONLY: Are you pregnant?
⚪ YES ⚪ NO

Do you require pre-medication prior to dental visits?
⚪ YES ⚪ NO
If **'Yes'**, Please list the reason why & date of procedure resulting in needing a Pre-Med prior to dental visits:

Reason: _____ Date: _____/_____/_____

Are you taking any medications (including birth control, vitamins, etc)? ⚪ YES ⚪ NO ⚪ N/A

Please Explain:

Do you have any known allergies? ⚪ YES ⚪ NO ⚪ N/A

Please Explain & List Reaction:

☐ Local Anesthetics _____	☐ Ibuprofen _____
☐ Codeine _____	☐ Penicillin _____
☐ Insulin _____	☐ Aspirin _____
☐ Barbiturates _____	☐ Iodine _____
☐ Latex _____	☐ Other: _____
☐ Metals _____	_____

Do you have any of the following?

☐ Anemia	☐ Cancer
☐ Stroke/Blood Clots	• Date Diagnosed: _____/_____/_____
☐ Blood Transfusions	• Type/Stage: _____
☐ Heart Disease	☐ Chemotherapy
☐ Artificial Heart Valve	☐ Radiation Therapy
• Date: _____/_____/_____	☐ Drug/Alcohol Dependency
☐ Congenital Heart Defects	• How Often: _____
☐ Rheumatic Heart Disease	☐ Mental Illness
☐ Angina	☐ Heart Murmur
☐ Heart Attack	☐ High Blood Pressure
• Date: _____/_____/_____	☐ Rheumatoid Arthritis
☐ Chest Pain	☐ Eye Disorders
☐ Pacemaker	☐ Epilepsy
• Date Placed: _____/_____/_____	☐ Seizures
☐ Tuberculosis	☐ Malignant Hyperthermia
☐ Asthma	☐ Kidney Disease
☐ Hay Fever	☐ DIabetes
☐ Emphysema	☐ Smoker
☐ Pneumonia	• If Previous Smoker, Date Stopped: _____/_____/_____
☐ Pleurisy	☐ Pins, Plates, Replacement Joints
☐ Thyroid/Adrenal Disease	• Date: _____/_____/_____
	• Replacement?:_____

To the best of my knowledge, all of the preceding information is true and correct.

First & Last Name: _____ Date: _____/_____/_____

Signature: _____

HIPAA

HIPAA is a federal law developed to give individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI that may be made by alternative means or correspondence.
The purpose of the Notice of Privacy Practice is to explain how Phillippi Dental may use or disclose your health care information. This Notice also explains the rights that you are guaranteed under HIPAA regulations. All information provided on this form is part of your Protected Health Information and will NEVER be shared with a 3rd party.

Patient Information

First Name: Last Name: Date of Birth: / /

Please provide us the best phone number(s) to contact you

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Work Phone: _____-_____-_____ EXT: _____

Please check the applicable box:

- ☐ Would you like to be notified of and confirm appointments via text messages and/or email?
- ☐ May we call the phone number(s) above and leave detailed voice messages regarding your appointments, billing matters and / or medical information?
- ☐ Would you like to receive special offers or internal promotions via emails?

Please list the person(s) you give permission to us to disclose your appointments, billing matters or medical information with.

Name: Relationship:

Name: Relationship:

Name: Relationship:

By signing below, I hereby acknowledge that I have received a copy of Phillippi Dental's Notice of Privacy Practice. I have read and understand this HIPAA privacy rule. I have also agreed to allow Phillippi Dental and the employees thereof to relay detailed messages regarding my appointments, billing matters and or medical information to myself or the above named representatives as specified.

Name of Signing Person: _____

Signature: _____ Date: _____/_____/_____