HEALTH HISTORY UPDATE

Last Name: _____ **First Name:** _____ **DOB:**_____ **DATE**_____

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

Home Phone:_____ **Cell:**_____ **Work:**_____

Dental Insurance: ☐ **Yes** ☐ **No** **SS#**_____ **Email Address:**_____

Medical History (Please check all that apply)

☐ Alcohol/Drug Addiction	☐ Cosmetic Surgery	☐ Heart Murmur	☐ Herpes/Cold Sores	☐ Sinus Problems
☐ Anxiety	☐ Cancer/Chemotherapy	☐ Headaches/Migraines	☐ Kidney Disease	☐ Stomach Problems
☐ Arthritis	☐ Diabetes	☐ Heart Murmur	☐ Liver Disease	☐ Stroke
☐ Artificial Joints	☐ Epilepsy/Seizures	☐ Heart Disease	☐ Mental Disorder_____	☐ Thyroid Disease
☐ Asthma	☐ Fainting/Dizziness	☐ Heart Attack	☐ Pacemaker	☐ Tuberculosis
☐ Blood Transfusion	☐ Glaucoma	☐ Hemophilia/Excessive Bleeding	☐ Rheumatic Fever	☐ Ulcers
☐ Back/Neck Problems	☐ High Blood Pressure	☐ Hepatitis, Type _____	☐ Respiratory Problems	☐ Venereal Disease

Please list any other conditions not listed above: _____

Do you need to take a Pre-Medication before Dental Appointments? _____

Are you allergic or have you ever reacted adversely to any of the following? (please check all that apply)

☐ Aspirin	☐ Hydrocodone	☐ Tetracycline
☐ Codeine	☐ Local Anesthetic	☐ Penicillin
☐ Erythromycin	☐ Nitrous Oxide	☐ Latex
☐ Epinephrine	☐ Sulfa Drugs	☐ Valium

Other Allergies:_____

Do you smoke or chew tobacco? ☐ Yes ☐ No **If yes, how much? _____

Physician's Name: _____ Date of Last Physical Examination: ____/____/____

Are you currently taking medication? ☐ Yes ☐ No

**If yes, please list: _____

Have you had any surgeries or been hospitalized in the past two years? ☐ Yes ☐ No

**If yes, for what reason? _____

Are you currently under the care of a physician for a specific condition? ☐ Yes ☐ No

If yes, please describe: _____

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____ Are you taking birth control? ☐ Yes ☐ No

Patient Signature:_____ Date: _____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____

Patient/Guardian Signature **Patient/Guardian Printed Name** **Date**

I authorize Tad Morgan, DDS & The Tyler Headache Center to discuss and release my medical information to:

Name	Relationship to patient	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all Physicians/Dentists you permit the release of Medical Records to:
(Include any doctor, dentist, pediatrician, lactation consultant, midwife, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____ _____

Patient/Guardian Signature **Patient/Guardian Printed Name** **Date**

_____ FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment was not obtained because:

- o Individual refused to sign
- o Communication barriers
- o An emergency situation
- o Other (specify):

_____