Patient Name _____ Date of Birth _____

Address _____

E-mail Address _____

Phone Number _____

Social Security Number _____

pierce & knight FAMILY DENTISTRY

Medical History Update

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

As applicable, explain next to questions below; please use comments section if additional space is required:

Are you under a physician's care now?	◯ Yes ◯ No
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No
Have you ever had a serious head or neck injury?	◯ Yes ◯ No
Are you on a special diet?	◯ Yes ◯ No
Do you use tobacco?	◯ Yes ◯ No
Do you use controlled substances?	◯ Yes ◯ No
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa drugs

◯ Other If yes, please explain: _____

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

AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis B	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Cold sores/fever blisters	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Yellow Jaundice	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No			
Convulsions	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

List all medications: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

pierce & knight
FAMILY DENTISTRY

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Electronic Signature Disclaimer

If you intend to electronically sign the Pierce & Knight Family Dentistry patient information, consent and policy statements, please read this carefully before signing.

By signing your name electronically on the prior documents listed below, you are agreeing that your electronic signature is the legal equivalent of your manual signature. A copy of these completed forms is available from our office upon request.

- ☑ Patient Information Form
- ☑ Medical History
- ☑ Consent to Treatment
- ☑ Patient HIPPA Consent Form
- ☑ Notice of Privacy Practices
- ☑ Financial & Cancellation Policies

Submit for Processing

To submit these forms to our office for processing, please complete one of the following actions:

E-MAIL: Compose an e-mail on your local device and attach a completed copy of these forms. Please send the e-mail directly to: pierceandknight@gmail.com

- OR -

PRINT: Print all completed pages enclosed in this information packet and bring them with you to your next appointment