# Medical History

Patient's Name: _____ Preferred Name: _____

Occupation: _____ General Dentist: _____

Physician: _____ Medical Specialist: _____

**Please *circle* the applicable answer. This information is used to assess the impact your health history may have on any treatment recommended.**

1. Do you feel nervous about having dental treatment? ..... Yes No
2. Are you currently taking or have you previously taken bisphosphonate medications for Osteoporosis such as Actonel, Fosamax or Zometa within the past 12 years?..... Yes No
3. In the last 24 hours have you used Cannabis, Cocaine, Ecstasy or Methamphetamines?..... Yes No

4. Do you have or have you ever had any of the following (please ***circle***)?

| | | | |
|---|---|---|---|
| AIDS/HIV Positive | Coronary Bypass | Hemophilia | Pacemaker |
| Alcohol/Chemical Dependency | Diabetes - Type 1 or 2 | Hepatitis A B C | Psychiatric Treatment |
| Arthritis | Epilepsy/Seizures | Herpes | Respiratory Problems |
| Artificial Joint | Glaucoma | High Blood Pressure | Rheumatic Fever |
| Asthma | Heart Attack | Kidney Disease | Stroke |
| Bleeding Disorder | Heart Defect | Liver Disorders | Tuberculosis |
| Blood Transfusion | Heart Murmur | Mitral Valve Prolapse | Ulcers |
| Cancer | Heart Valve Replacement | Osteoporosis | Venereal/Communicable Disease |

5. Have you had/do you have any other serious medical condition not listed above? ..... Yes No
   If yes, please describe: _____

6. Do you have any allergies or sensitivities to the following:

| | | | | |
|---|---|---|---|---|
| Penicillin | Erythromycin | Tetracycline | Sulfa | Demerol |
| Percodan | Aspirin | Valium | Codeine | Latex |

Local Anesthetic or other (please list): _____

7. **Are you taking any drugs or medications now? If YES, please list ALL including herbal remedies such as St. John's Wort and over the counter medications?** _____

_____

_____

_____

8. Have you ever had an unfavorable reaction to dental treatment? ..... Yes No
   If yes, please describe _____
9. Do you premedicate with antibiotics prior to **ALL** dental appointments?..... Yes No
   If yes, what do you take? _____
10. **FEMALE PATIENTS**: Are you trying to conceive, pregnant or nursing? ..... Yes No
    Do you take birth control pills? ..... Yes No

***Turn Over***

***Consent to Disclosure of Patient Information:***

***This allows our office (Dr. Hugh Maguire Inc.) to send any dental reports, dental images as well as any dental insurance claims via electronic communication.***

I provide Dr. Hugh Maguire Inc. and its servants, agents and employees (the "Authorized Party") full power and authority to disclose information accumulated or derived from my relationship as patient, to any person who is lawfully entitled to request it, and further such information may be transmitted or conveyed by the Authorized Party through the most convenient or efficient manner available, including unsecured digital or electronic formats, in the sole discretion of the Authorized Party.

I waive any rights that I may have in respect of the disclosure or transmission of the information as set out in this Authority.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

***Consent for Consultation***

I authorize Dr. Maguire to consult with my physician(s) or other health professionals to seek clarification on the effect of my previous or present medical or dental condition on any proposed endodontic treatment. I also authorize and request Dr. Maguire to perform an endodontic examination and any such tests/x-rays/scans as required. To avoid any misunderstandings regarding dental insurance, we want our patients to know that all professional services are charged directly to the patient and that the patient is PERSONALLY responsible for payment of fees. **WE DO NOT RENDER SERVICES ON THE BASIS THAT INSURANCE COMPANIES WILL PAY OUR FEES.**

**Date:** _____ **Signature:** _____

**Review and initial when updated at *return visits*:** **Date:** _____ **Initial:** _____

**Date:** _____ **Initial:** _____