Compass Health Network

Name: _____DOB: _____

Patient Medical History

Physician:_____ **Office Phone:**_____ **Date of last exam:**_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any Surgeries in the last 5 years? If yes, please explain_____ _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ _____ _____ _____	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Have you ever taken bisphosphonate therapy (e.g. Fosamax, Boniva)?	☐	☐
6. Do you use tobacco/vape?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Do you have a history of drug/alcohol abuse?	☐	☐
9. Have you ever had any prolonged bleeding following a surgical procedure including tooth extractions?	☐	☐
10. Are you taking anticoagulant therapy (e.g Coumadin, Plavix)	☐	☐

	Yes	No
11. Do you have any disabilities? If yes, please explain: _____	☐	☐
12. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals e.g. nickel, mercury, etc	☐	☐
Latex Rubber	☐	☐
Codeine	☐	☐
13. **FOR WOMEN ONLY**		
Are you pregnant or think you may be? If yes, when are you due? _____	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐
14. Are you currently feeling like harming yourself and/or others?	☐	☐

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

	Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse	☐	☐	Recent Weight Loss	☐	☐	Respiratory Problem	☐	☐
Joint Replacement or Implant	☐	☐	Epilepsy/Convulsions	☐	☐	Easily Winded	☐	☐
Heart Surgery	☐	☐	Cancer	☐	☐	Asthma	☐	☐
Heart Attack	☐	☐	Leukemia	☐	☐	Emphysema	☐	☐
Stroke	☐	☐	Back/Neck Problems	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Diabetes	☐	☐	Thyroid Problem	☐	☐
Swollen Ankles	☐	☐	Rheumatic Fever	☐	☐	Tuberculosis	☐	☐
Heart Disease/Trouble	☐	☐	Kidney Diseases	☐	☐	Frequently Tired	☐	☐
Cardiac Pacemaker	☐	☐	Jaundice	☐	☐	Stomach Troubles/Ulcers	☐	☐
Chest Pains/Angina	☐	☐	Anemia	☐	☐	Arthritis	☐	☐
Fainting/ Seizures	☐	☐	Radiation Therapy	☐	☐	Sexually Transmitted Disease	☐	☐
High Blood Pressure	☐	☐	Glaucoma	☐	☐	AIDS or HIV Infection	☐	☐
Low Blood Pressure	☐	☐	Hay Fever/Allergies	☐	☐	Hepatitis	☐	☐

Other:_____

Compass Health Network

Name: _____DOB: _____

Patient Dental History

Name of Previous Dentist and Location_____

Date of Last Exam_____

Preferred Pharmacy_____

Pharmacy phone _____

Pharmacy address _____

	Yes	No
1. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
2. Do you feel pain in any of your teeth?	☐	☐
3. Do you clench or grind your teeth?	☐	☐
4. Have you had any head, neck, or jaw injuries?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date