Hillcrest Dental Care
788 South St, Pittsfield MA 01201

Medical History Update

Patient Name: ______________________ Address: ______________________________

Home Phone: ____________ Cell Phone: _____________ Work Phone: ______________

- Name of Physician? ____
- Date of Last Medical Exam? ____
- Are you under the care of a Physician? ________ If so, why? ______________
  ____
- Are you taking any medications? _________ List _______________________
  ____
  ____
- Do you need Pre-Med (Antibiotics) before Dental Treatment? ______________

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

	Yes	No		Yes	No
Heart Disease	____	____	Aids (HIV)	____	____
High Blood Pressure	____	____	Rheumatic Fever	____	____
Stroke	____	____	Hepatitis Type __	____	____
Artificial Valve, Joints	____	____	Ulcer	____	____
Respiratory Problems	____	____	Abnormal Bleeding	____	____
Diabetes	____	____	Mental Disorders	____	____
Epilepsy	____	____	Cancer	____	____
Allergies to Medicine	____	____	Radiation Treatment	____	____
Currently Pregnant	____	____	Tuberculosis	____	____

- Are you allergic to any medications? _______ List _______________________
- Have you had any recent surgery, or been hospitalized? ____________________
  ____
- Is there anything else we should know about your medical history? ___________
  ____
- Has your insurance information changed? _______________________________

I hearby authorize Hillcrest Dental Care to provide my dental treatment and to furnish information to my insurance carrier concerning diagnosis and treatment. Permission is given for release of my medical information to authorized individuals pertaining to continuity of care. **I understand that I am financially responsible for any or all of my bill that is not completely paid for by my insurance carrier.**

______________________________ ________________________
Patient/ Guardian Signature Date

___________ _______
Provider Initials Date

9/2011