Patient Update

Name: _____Date _____

Address: _____

Phone number: _____

Email address: _____

HEALTH HISTORY

Indicate which of the following you have had or currently have by checking yes or no in each box.

Yes	No	Condition	Yes	No	Condition
☐	☐	Pre-med (Amox)	☐	☐	Anemia
☐	☐	Pre-med (Clinda)	☐	☐	Arthritis
☐	☐	Pre-med (other)	☐	☐	Artificial joints
☐	☐	Allergies	☐	☐	Asthma
☐	☐	Allergy- Aspirin	☐	☐	Blood Disease
☐	☐	Allergy- Codeine	☐	☐	Blood Thinners
☐	☐	Allergy- Erythro	☐	☐	Cancer
☐	☐	Allergy- Hay Fever	☐	☐	Diabetes
☐	☐	Allergy- Latex	☐	☐	Dizziness
☐	☐	Allergy- Penicillin	☐	☐	Epilepsy
☐	☐	Allergy- Sulfa	☐	☐	Excessive Bleeding
☐	☐	Allergy- Other	☐	☐	Fainting
☐	☐	Glaucoma	☐	☐	Head Injuries
☐	☐	Heart Disease	☐	☐	Heart Murmur
☐	☐	Heart Stents	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	HIV
☐	☐	Jaundice	☐	☐	Kidney Disease
☐	☐	Liver Disease	☐	☐	Mental Disorders
☐	☐	Nervous disorders	☐	☐	Pacemaker
☐	☐	Pregnancy	☐	☐	Radiation Treatment
☐	☐	Respiratory Problems	☐	☐	Rheumatic Fever

☐ ☐ Rheumatism
☐ ☐ Stomach Problems
☐ ☐ Tuberculosis
☐ ☐ Ulcers
☐ ☐ Other

☐ ☐ Sinus Problems
☐ ☐ Stroke
☐ ☐ Tumors

For any condition or alert with a Yes checked- please explain:
_____

☐ By checking this box, I attest that the information above is correct and it is MY responsibility to let the office know of any changes in my health

Signed _____Date _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature _____ Date_____