Patient Name:

RODNEY SHIVERS, D.D.S. **Eaglesoft Medical History**

Birth Date:

Date Created:

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 questionship.

Are you under a physiciant's care now? Yes No If yes	Are you under a physic			,m,	~					
operation? Heav you ver take a serious head or neck injury? Yes No If yes Do you take, or have you taken, Phen-Fen or Reduc? Yes No If yes Do you take, or have you taken, Phen-Fen or Reduc? Yes No If yes Do you take, or have you taken, Phen-Fen or Reduc? Yes No If yes Do you take, or have you taken, Phen-Fen or Reduc? Yes No If yes Do you take n Fosamax, Bonka, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you set tobacco? Yes No Domen: Are you Perganant/Trying to get pregnant? Norsing? Taking oral contraceptives? Perganant/Trying to get pregnant? Penicillin						If yes				
Are you taking any medications, pills, or drugs?		spitalized or had	l a major	O Yes () No	If yes				
Do you take, or have you taken, Phen-Fen or Redux?	Have you ever had a se	rious head or n	eck injury?	O Yes (⊃No	If yes				
Hove you ever taken Fosamax, Bonlva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Yes No	Are you taking any med	dications, pills, o	r drugs?	O Yes (⊃No	If yes				
Any of the medications containing bisphosphonates? Are you on a special diet? Or you use tobacco? Orden: Are you Orden: A	Do you take, or have yo	ou taken, Phen-I	en or Redux?	O Yes	○No	If yes				•
Are you on a special diet?				○ Yes	○No	If yes				
Or you use tobacco?		_	ospnonates?	(Yes () No					
Pregnant/Trying to get pregnant?										
re you alergic to any of the following? Aspirin	/omen: Are you	***************************************	***************************************	······································	***************************************	***************************************				
Aspirin	Pregnant/Trying to	get pregnant?	Ĺ	Nursing	J?			☐ Taking or	al contraceptives?	
Metal	re you allergic to any of	the following?						***************************************		
If yes Do you use controlled substances? Yes No If yes Do you use controlled substances? Yes No If yes Do you use controlled substances? Yes No If yes Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Diabetes Yes No No Alzheimer's Disease Yes No Diabetes Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Herps Yes No High Cholesterol Yes No Scarlet Fever Yes No Arthrificial Joint Yes No Excessive Bleeding Yes No Asthma Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Broathing Problems Yes No Frequent Diarrhea Yes No Bruise Easily Yes No Galiator Treatments Yes No Hepatitis B or C Yes N	, mm,							dammanini		
Do you use controlled substances? Yes No If yes	Metal		Latex				Sulfa Drugs		Local Anesthetics	
AIDS/HIV Positive Yes No Cortisone Medicine Yes No Diabetes Yes No Diabetes Yes No Diabetes Yes No Diabetes Yes No Drug Addiction Yes No Anaphylaxis Yes No Anaphylaxis Yes No Easily Winded Yes No Anglina Yes No Emphysema Yes No Emphysema Yes No Emphysema Yes No Emphysema Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Excessive Bleeding Yes No Blood Disease Yes No Frequent Cough Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Breathing Problems Yes No Genital Herpes Yes No Congerital Heart Disorder Yes No Heart Murmur Yes No Congerital Heart Disorder Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Congerital Heart Discorder Yes No Heart Trouble/Disease Yes No No Heart Trouble/Disease Yes No Yes No Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Yes	Other?					If yes				
AIDS/HIV Positive	Do you use controlled s	ubstances?		○ Yes (⊃No	If yes				
Alzheimer's Disease	you have, or have you	had, any of the	following?							
Anaphylaxis	AIDS/HIV Positive	○ Yes ○ No	Cortisone Med	licine	○ Yes	○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ N
Anemia	Alzheimer's Disease	○ Yes ○ No	Diabetes		○ Yes	○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ N
Angina	Anaphylaxis	○ Yes ○ No	Drug Addiction	1	(Yes	○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ N
Angina	Anemia	○ Yes ○ No	Easily Winded		(Yes	○ No	Herpes	○ Yes ○ No	,	○ Yes ○ N
Arthritis/Gout	Angina	○ Yes ○ No	1 *		(Yes	○ No				
Artificial Heart Valve	a real source operate			izures	2000				1 2.1.5 511.00555550301	
Artificial Joint		760			15550	Section 1	_		The second of the second	
Asthma				~					_	
Blood Disease										1,000
Blood Transfusion			1				_	750		
Breathing Problems							•	100		
Bruise Easily					200			1000		
Cancer	1.50	1000			7440			-		
Chemotherapy				3		12.000		THE STATE OF THE S	_	
Chest Pains										
Cold Sores/Fever Blisters Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No No Convulsions Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No			Hay Fever				Mitral Valve Prolapse		Tonsillitis	○ Yes ○ N
Congenital Heart Disorder	Chemotherapy	1000	Heart Attack/F	ailure	O Yes	○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ N
Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No Yellow Jaundice Yes No	Chest Pains		Heart Murmur		○ Yes	○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ N
Yellow Jaundice O Yes O N	Chest Pains	s 🔾 Yes 🔾 No			OVAL	○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ N
	Chest Pains Cold Sores/Fever Blister		Heart Pacema	ker	/ 123					
	Chest Pains Cold Sores/Fever Blister Congenital Heart Disorder	○ Yes ○ No	New Charles and the Control of the C		***	○ No	Psychiatric Care	○ Yes ○ No		1000

X

Date:_____

RODNEY E. SHIVERS, D.D.S.

We would like to welcome you to our office. We are pleased you have chosen us to work with you in maintaining your dental health. If you have any questions regarding this form, please ask our staff for assistance.

Name	MIDDI	E INITIAL		LAST	
Address					
City		State	e 7	Zip Code	
Home #	Office #	- with	Cell =	#	
Birthdate	SSN		7 10 10 A A A A A A A A A A A A A A A A A	_ Male	_ Female
Single_	Married Divo	orced	Widowed		
Emergency Contact _			VII III		
Relationship		Cont	act #	-1700-	1100
**Would you prefer	e-mail or text notification (Please circle your pr			intments?	
If you prefer e-mail, j	please list address assoc	iated wit	th cell #	7.114.200	***
Whom may we thank	x for referring you to our	office?_			
	INSURANCE	INFORI	MATION		
Name of Insured (if o	other than patient)				
Relationship to Patie	nt	_SSN or I	ID#		
Employer		Insura	ance Co		
	surance benefits to Rodi records to my insuranc	-			ize release of
Signature	of parent or guardian if p		Dat	e	
(Signature o	f parent or guardian if p	atient is	a minor)		