

# MASHBURN, ZSAMBEKY, ROGERS & ASSOCIATES

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David L. Mashburn, D.D.S.      Jonathan T. Zsambecky, D.D.S.      Robert C. Rogers Jr., D.D.S.      Thomas R. Ferrell, D.D.S.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No      If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No      Nursing?  Yes  No      Taking birth control pills?  Yes  No

Check YES or NO to the following: Describe any YES answers: \_\_\_\_\_

YES NO	YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> AIDS	<input type="checkbox"/> <input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Skin Rash
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Cough up Blood	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Nervous Problems	<input type="checkbox"/> <input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Back Problems	<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Recent Surgery (last 2 yrs.)	
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease	
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> <input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> <input type="checkbox"/> HIV Positive	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath	

## MEDICATIONS

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## ALLERGIES

Aspirin       Penicillin

Barbiturates (Sleeping pills)       Sulfa

Codeine       Other \_\_\_\_\_

Local Anesthetic

None

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_

### Acknowledgment of Receipt of Notice of Privacy Practices

I have read the Notice of Privacy Practices for the above named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_