Karin Cross
RDHAP LIC # 1010
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PATIENT HISTORY FORM

Patient's Name: ____**Birthdate:** _____/_____/_____ **Sex:** _______________

Responsible Party Name : ________________________________**Affiliation:** _____________________________________

Address:____**City:**_____________________**State:**________________

Zip: ______________ **Phone:** ______________________ **Cell Phone:** _________________ **email:** ____________________

Facility Name: ____ **Phone:** ____________________________

Facility Contact Name: _______________________________________ **Title:** ______________________________

Name of Physician: ____ **Phone:** ______________________________

Date of last appt.: ___________________________________ **Reason:** ____

Name of Dentist ____________________________________ **Phone:** _____________________________________

Date of Last Dental Cleaning: _________________________________**Date of last x rays:** ____________________

Please Circle all that apply:

Heart Murmur	yes	no	Radiation Therapy	yes	no
Therapy Mitral Valve Prolapse	yes	no	Hemophilia	yes	no
Multiple Sclerosis	yes	no	Hepatitis A, B or C	yes	no
Diabetes	yes	no	Deaf	yes	no
Stroke	yes	no	Dementia	yes	no
Autism	yes	no	Lives Disease	yes	no
High Blood Pressure	yes	no	Heart Pacemaker	yes	no
Cerebral Palsy	yes	no	Hip/Joint Replacement	yes	no
H.I.V.	yes	no	Blindness	yes	no
Epilepsy or Seizure	yes	no	Allergies	yes	no
Parkinson's Disease	yes	no	Alzheimer's disease	yes	no
Heart Disease	yes	no	Lung disease	yes	no

Describe current or long – term disability/ medical condition: ____

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List of Medications :____

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Please list any allergies: ____

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Signature of Patient/Custodial/ Guardian: _________________________________ **date:** ____________________