MEDICAL HISTORY

Patient Name_____NickName_____Age_____

Name of Physician_____

Date of last Medical Doctor's visit_____ Purpose_____

HAVE YOU EVER HAD THE FOLLOWING: YES NO

1. a hospitalization for illness or injury ..... ❑ ❑
2. allergic reaction to
   - ❑ aspirin
   - ❑ penicillin
   - ❑ erythromycin
   - ❑ codeine
   - ❑ local anesthetic
   - ❑ metals (gold, stainless steel)
   - ❑ any other medications_____
3. heart problems ..... ❑ ❑
4. high blood pressure ..... ❑ ❑
5. a stroke ..... ❑ ❑
6. heart valve ..... ❑ ❑
7. prolonged bleeding due to a slight cut ..... ❑ ❑
8. tuberculosis ..... ❑ ❑
9. asthma ..... ❑ ❑
10. kidney/liver disease ..... ❑ ❑
11. thyroid disease ..... ❑ ❑

YES NO

12. gastric reflux ..... ❑ ❑
13. diabetes ..... ❑ ❑
14. arthritis ..... ❑ ❑
15. glaucoma ..... ❑ ❑
16. head or neck injuries ..... ❑ ❑
17. epilepsy, convulsions (seizures) ..... ❑ ❑
18. cold sores ..... ❑ ❑
19. hepatitis (type_____) ..... ❑ ❑
20. HIV / AIDS ..... ❑ ❑
21. tumor, cancer, abnormal growth ..... ❑ ❑
22. radiation/chemotherapy therapy ..... ❑ ❑

ARE YOU:

23. presently being treated for any illness ..... ❑ ❑
24. a smoker ..... ❑ ❑
25. FEMALE-taking birth control ..... ❑ ❑
26. FEMALE – pregnant ..... ❑ ❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

_____

List any medications taken within the last two years

_____

Have you ever take medication for osteoporosis like Fosamax, Actonel, Boniva, Zometa or Aredia? Please list dates and medication.

_____

I consent to dental treatment. I understand that dental treatment involves medical procedures. Medical procedures involve the risks associated with drugs and surgery. If I do not understand the care that will be provided to me, I know that I can ask for and receive an explanation.

Patient (Or Guardian) Signature _____Date_____

Doctor's Remarks _____

Updated _____
Updated _____
Updated _____

Confidential Information Questionnaire

Please Print

Patient's name last first middle	Date of birth	Contact phone ☐C ☐H
Patient's address street apt# city	state zip	2nd contact phone number
E-mail Address	Social Security #	Best time to call
Person we can contact in case of an emergency (other than your family home) Name Relationship Phone Number		
Other family members that are patients here	Who can we thank for referring you to our office	

Insurance and Financial Information

Insurance coverage ☐ Yes ☐No	Name Insurance is Under	Patient's relationship
Insurance company name and address		Insured's SSN
Employer	Occupation	Date of birth
Work address	Marital status ☐M ☐S ☐D ☐W	Group/program #
Secondary coverage ☐ Yes ☐ No	Name Insurance is Under	Patient's relationship
Insurance company name and address		Insured's SSN
Employer	Occupation	Date of birth
Work address	Does 2nd insurance coordinate benefits?	Group/program #

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize that the doctor can use my records if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policies including collection fees for past due accounts.

I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of the same by the doctor in scientific papers of demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved and consent to dental treatment for myself or child.

Signature_____Date_____