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	Social Security #
Patient's address street apt# city state zip			Home phone
Marital status ☐M ☐S ☐D ☐W	Patient's/guardian's employer		Occupation
Work address street city state zip		Work phone	E-mail Address Home
Spouse's name last first middle		Spouse's employer	Occupation
Work address street city state zip		Work phone	E-mail Address Work
Person we can contact in case of an emergency (other than your family home) Name relationship work# home#			
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	Insurance company name insurance address		
Subscriber's name	Patient's relationship to subscriber	Subscriber's date of birth	Subscriber's SSN
Group/program #	Employer (if different from above)	Employer address	
Secondary coverage ☐ Yes ☐ No	Insurance company name insurance address		
Subscriber's name	Patient's relationship to subscriber	Subscriber's date of birth	Subscriber's SSN
Group/program #	Employer (if different from above)	Employer address	

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_____