PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP | Heart Rate:

Height:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Blood Thinners Aspirin Daily
☐ ☐	Joint Replacement
☐ ☐	Heart Disease
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Artificial Heart Valve
☐ ☐	Blood Transfusion
☐ ☐	Rheumatic Heart Disease
☐ ☐	Pace Maker
☐ ☐	Angina Pectoris
☐ ☐	High/Low Blood Pressure
☐ ☐	Anemia
☐ ☐	Organ Transplant
☐ ☐	Hepatitis
☐ ☐	Liver Disease
☐ ☐	Stroke
☐ ☐	Diabetes
☐ ☐	Arthritis
☐ ☐	Frequent Headaches
☐ ☐	Fainting Spells
☐ ☐	Epilepsy

Y N	Conditions
☐ ☐	Kidney Problems
☐ ☐	Alcohol Abuse
☐ ☐	Drug Abuse
☐ ☐	Asthma
☐ ☐	Difficulty Breathing
☐ ☐	Tuberculosis
☐ ☐	Cancer- Chemo/Radiation Therapy
☐ ☐	Glaucoma
☐ ☐	Venereal Disease
☐ ☐	HIV+ AIDS
☐ ☐	Cosmetic Surgery
☐ ☐	Psychiatric Problems
☐ ☐	Anxiety
☐ ☐	Thyroid Problems
☐ ☐	Ulcers
☐ ☐	Acid Reflux
☐ ☐	Eating Disorder
☐ ☐	Fever Blisters
☐ ☐	Dry Mouth
☐ ☐	Sinus Problems
☐ ☐	Local Anesthetic Reactions
☐ ☐	Jaw Pain -TMJ

Y N	Conditions
☐ ☐	Clenching / Grinding
☐ ☐	Snore / Sleep Apnea
☐ ☐	Bleeding Gums
☐ ☐	Painful/Loose Teeth
☐ ☐	Diet- High Sugar
☐ ☐	Sensitive Teeth

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

PRIVACY NOTICE

You entrust us with personal information and we take that very seriously. We take physical and procedural safeguards to protect your personal information, and do not share nonpublic personal information except as necessary to assist you with insurance reimbursement or to ensure optimal care. Our office "Notice of Privacy Practices" is posted in the reception area, and copies are available at your request.

If you have any specific requests regarding your personal information please let us know.

FINANCIAL POLICY

For our patients convenience, we accept payment directly from insurance companies *when possible.*

With the exception of some preventative services, it is rare for dental insurance to cover the entire fee for services. Copayments or portions of fees not covered by insurance are collected at the time of service. We accept cash, checks, Mastercard, Visa and American Express.

We will estimate your out of pocket expense for dental treatment based on information provided by insurance companies. These are estimates only and from time to time insurance will cover less or more than expected. All fees are ultimately the responsibility of the patient regardless of insurance reimbursement. Please call your insurance company or speak to your employer for specific questions regarding your insurance plan.

In situations where we cannot accept payment directly from the insurance company (such as plans that only will pay the insured person directly) we will request payment at the time of service and submit the forms for you so you may be reimbursed directly.

CONSENTS AND AUTHORIZATION

X-rays are a necessary and appropriate diagnostic aid. We take the fewest number of x-rays possible, and take them digitally to limit exposure, with a frequency as recommended by the American Dental Association. We will routinely take these necessary x-rays for you (or your dependent) unless you specifically advise us otherwise. Refusal to take x-rays may make it impossible for us to treat you properly.

Photographs are taken routinely for diagnostic purposes. It is possible that these photographs may be used for lecture / educational purposes or for demonstration purposes for other patients. Please advise us if you do not wish your photographs to be used in this manner.

There are many variables affecting dental health and as such no guarantees can be made concerning the results of treatments or procedures.

Fortunately, complications resulting from dental treatment are very infrequent. There is however, some risk involved with all dental procedures. The administration of local anesthetics (novocaine), extractions, implant placement and placement of all types of dental restorations carry a small risk of postoperative discomfort, or possible need for further treatment. We will routinely discuss these small risks with you before your treatment.

APPOINTMENTS

We attempt to offer appointment times to satisfy most patient's schedules.

Frequently missed or cancelled appointments make it impossible to treat patients properly. Habitual missed or cancelled appointments may result in dismissal from the practice.

SIGNATURE

1. I understand that the information given is correct to the best of my knowledge, and will notify the doctor or his staff if there are any changes.
2. I have had the opportunity to review the office Notice of Privacy Practices, and understand my personal information will not be used other than to ensure proper care or for the office to receive payment for services.
3. I consent to use of x-rays, anesthetics and other materials and medications necessary for my dental care. I understand dental procedures carry a small risk and no guarantees can be made in regard to treatment outcomes.
4. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier may pay less than the actual bill for services, and that I am financially responsible for payment of my (or my dependents) account.

Signature (Patient, Parent or Guardian) _____

Office Use Only: HIPAA requests Y N Reviewed by: