MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient Registration

Patient Details

Patient First Name	Last Name	Middle Initial
Preferred Name	Sex ☐ Male ☐ Female	
Address		
City, State Zip		
Email Address	Prefer email for appointment reminders? ☐ Yes ☐ No	
Preferred Phone Number	Alternate Phone Number	
Work Phone Number	Insurance ID #	
Birth Date	Age	Social Security
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed		
Date of Last Dental Visit	Reason for Today's Visit	
How Did you Find Our Office? (Circle One) **Phonebook Newspaper Insurance Doctor Drove By Dental Society Radio Facebook Other - _____ Friend/Family - Who _____**	**Preferred Dentist (if any)**	

Responsible Party/Parent/Guardian

Required if patient is a minor/dependant

First Name	Last Name	Middle Initial
Address		
City, State Zip		
Preferred Phone Number	Alternate Phone Number	
Birth Date	Social Security	

Insurance Information

Please present your card at each visit

Primary Insurance		Secondary Insurance	
Name of Insured		Name of Insured	
Insured DOB	Insured SS #	Insured DOB	Insured SS #
Insured Address		Insured Address	
Insured City, State Zip		Insured City, State, Zip	
Insured Phone		Insured Phone	
Employer		Employer	
Insurance Company		Insurance Company	

Please Remember: Our office requires 24 hours notice when canceling an appointment

Buckeye Dental Group LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Buckeye Dental Group
7265 Portage Street NW Suite A, Massillon, OH 44646
330-498-9730 Fax: 330-498-9753

I acknowledge that I have been provided a copy of Buckeye Dental Group's Notice of Privacy Practices, which has an effective date of 01 / 01 / 2015, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient or Patient's Representative: _____ Date _____

Print Name: _____

Relationship to Patient (If not signed by the Patient): _____

Payment Information

Please remember payment is expected when services are performed. If procedures are covered in whole or in part by dental insurance, I authorize payment to Buckeye Dental Group. Insurance coverage noted is only an estimate and may be incorrect. I understand that I am responsible for the difference between the cost of treatment and what is covered by my insurance.

Any checks returned or re-deposited will result in a fee of up to $20 per transaction.

After 30 days, the unpaid balance will be subject to interest at 1% of the remaining balance. Any and all balances will be my responsibility, in accordance with the credit policy (available upon request).

If there is a divorce involved, please remember that our policy requires that regardless of which parent is responsible for payment of medical services; PAYMENT IS DUE AT THE TIME OF SERVICE. The person that brings the child in the office for the appointment is expected to make a payment. As you should be able to understand, we are not subject to your divorce decree and will not be involved in divorce disputes.

_____ _____
Signature Date

Please read and initial below:

_____ I understand that in order for Buckeye Dental Group to keep office fees from rising, any co-pay, co-insurance or deductible that I owe must be paid at the time of service.

_____ I understand that Buckeye Dental Group requires that I give at least 24 hours notice when unable to make a scheduled appointment. I understand that Buckeye Dental Group may discontinue treating me if I am unable to give that notice.

Consent for Treatment of a Minor

I am the Parent / Guardian of _____ who is a minor child, and I authorize examination and treatment as
Name of Child
necessary by or under the supervision of Buckeye Dental Group.

This includes exposure of radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate medications and materials for treatment.

_____ _____ Angela Eshelman
Parent or Guardian Signature Date Witness