Medical and Dental History

This information is requested in order that I may thoroughly diagnose and treat your condition. All information will be held in strict confidence. Please provide the most complete information possible. Thank You.

Name _____ SS# _____ Birthday _____

Referred by ☐ Sign ☐ Ad ☐ Doctor ☐ Friend/Family Name _____

Marital Status Date of last dental visit_____

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Male ☐ Female Reason for Visit_____

Residence Address _____ Employer _____

City, State, Zip _____ Employer Address _____

Telephone _____ City, State, Zip _____

Email Address _____ Telephone _____

☐ Yes ☐ No *Are you having pain or discomfort?*

☐ Yes ☐ No *Do you feel nervous about having dental treatment? Have you ever had a bad experience in the dental office?*

☐ Yes ☐ No *Have you been under the care of a medical doctor during the past two years?*
Physicians Name _____
Address _____

☐ Yes ☐ No *Have you taken any medications or drugs during the past two years? Are you now taking any medications, drugs, or pills?* If yes, please list:_____

☐ Yes ☐ No *Are you allergic or have you reacted adversely to any of the following medications?*

Aspirin	Demerol	Novocain	Percodan	Sulfa Drugs	Xylocaine
Codeine	Erythromycin	Other Antibiotics	Scopolamine	Tetracycline	
Darvon	Nitrous Oxide	Penicillin	Sleeping Pills	Valium	

☐ Yes ☐ No *Are you aware of being allergic to any other medication or substance (Latex or rubber products)? If yes, please list*: _____

Circle any of the following you have had or have at present:

Allergies or hives	Colitis	Hepatitis A, B , C (circle)	Mitral Valve Prolapse	Surgical implant, describe:
Anemia	Diabetes	High blood pressure	Psychiatric treatment	_____
Arthritis	Epilepsy or seizures	HIV Positive, A.I.D.S.	Respiratory disease	Thyroid disease
Artificial heart valve	Fainting	Jaw pain	Rheumatic Fever	Tobacco habit
Artificial Joint (hip, knee)	Glaucoma	Kidney disease	Emphysema	Tuberculosis
Asthma	Hay Fever	Liver disease	Rheumatism	Ulcer
Cancer	Heart Murmur	Low blood pressure	Stroke	Venereal disease
Chemotherapy	Heart Problems	Material allergies (latex, metal)		

☐ Yes ☐ No D*o you have any disease, condition, or problem not listed?* _____

☐ Yes ☐ No *Are you on a special diet or taking natural substances (Herbs/Vitamins/Over the counter medications)? If yes, please list:*_____

For Women only:

☐ Yes ☐ No *Are you pregnant? If yes, what month?*_____ ☐ Yes ☐ No *Are you taking birth control pills?*

Authorization – Please review & sign below to confirm that you have read & understand our office policies & procedures.

- ☐ I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. If there is any change in my medical status, I will inform the dentist.
- ☐ The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.
- ☐ I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- ☐ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges and for **understanding my insurance benefits and coverage**.
- ☐ I understand that **any unpaid balance not paid for any reason by the insurance company is my responsibility** and an 18% interest charge will be billed on accounts 60 days past due.
- ☐ I understand that the summary of dental benefits obtained from the insurance company is an estimate and not a promise to pay.
- ☐ **Missed** or **cancelled** appointments without 24 hours prior notice will incur a **$25 fee** to your account.

_____ _____

Signature Date