DENTAL ASSOCIATES, P.A.

www.dentalassociatespa.com
2300 Pennsylvania Ave, | Suite 6 C & D • Wilmington, DE 19806 (302)571-0878

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) ___ (MI)

_____ (Preferred Name)

Please take a moment to answer a few questions and let us know about or update your medical and dental history.

Please indicate if any of the following apply to you:

- ☐ Acid Reflux/GERD
- ☐ Allergy-Clindamycin
- ☐ Allergy-Penicillin
- ☐ Angina/Chest Pain
- ☐ Back Problems
- ☐ Bruise Easily
- ☐ Cold Sores
- ☐ Emphysema/COPD
- ☐ Fen-Phen Medications
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Menopause
- ☐ PREMED
- ☐ Scarlet Fever
- ☐ Smoker/ Chew Tobacco
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ ADD/ADHD/Lrng Disabi
- ☐ Allergy-Latex
- ☐ Allergy-Sulfa
- ☐ Arthritis
- ☐ Biologic Medications
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Endocarditis
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Mitral Valve Prolaps
- ☐ Radiation Treatment
- ☐ Seasonal Allergies
- ☐ Stomach Problems
- ☐ TMJ/Joint Pain
- ☐ Venereal Disease
- ☐ Allergy- Codeine
- ☐ Allergy-Local Anes.
- ☐ Alzheimer's/Dementia
- ☐ Asthma
- ☐ Bisphosonate Meds
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Headaches
- ☐ Heart Valve Replaced
- ☐ HIV+/AIDS
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Allergy-Aspirin
- ☐ Allergy-NSAIDs
- ☐ Anemia
- ☐ Autoimmune Disease
- ☐ Blood Disease
- ☐ Chemotherapy
- ☐ Dizziness/Fainting
- ☐ Excessive Bleeding
- ☐ Heart Attack
- ☐ Hepatitis Type ____
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Rheumatism
- ☐ Sleep Apnea
- ☐ Swelling of Limbs
- ☐ Tumors

WOMEN ONLY: If you are currently pregnant, what is your due date? _____

Please list any other health issues or allergies (i.e. acrylic, metals, etc.) not listed on the prior page.

_____

_____

_____

Please list all prescription and over-the-counter medications you are currently taking.

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ _____

Date

Relationship to Patient:

Response Date: _____