Medical History Form

Date ____________________

Name ____ Home Phone (____)____________
Last First Middle

Mailing Address ______________________________________ Business Phone (____)____________

City ______________________ Prov.____________ Postal Code ____________

Occupation : ______________________ Email: ______________________

Date of Birth ____/____/____ Sex M F Height__________ Weight __________ Single __________ Married __________
day month year

Name of Spouse ______________ **OR** - Closest Relative ______________ Phone (____) ____________

If you are completing this form for another person, what is your relationship to that person? ____________

Referred by ______________________

For the following questions, circle *yes* or *no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Yes No **1.** Has there been any change in your general health within the past year?
2. My last physical examination was on ______________________
Yes No **3.** Are you now under the care of a physician?
If so, what is the condition being treated? ______________________
4. The name and address of my physician(s) is ______________________
____

Yes No **5.** Have you had any serious illness, operation, or been hospitalized in the past 5 years?
If so, what was the illness or problem? ______________________
Yes No **6.** Are you taking any medicine(s) including non-prescription medicine?
If so, what medicine(s) are you taking? ______________________

7. Do you have or have you had any of the following diseases or problems?
- Yes No **a)** Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease
- Yes No **b)** Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
  - Yes No **1)** Do you have chest pain upon exertion?
  - Yes No **2)** Are you ever short of breath after mild exercise or when lying down?
  - Yes No **3)** Do your ankles swell?
  - Yes No **4)** Do you have inborn heart defects?
  - Yes No **5)** Do you have a cardiac pacemaker?
- Yes No **c)** Do you have any artificial joints? (i.e. hip, knee)

- Yes No **d)** Allergy
- Yes No **e)** Sinus trouble
- Yes No **f)** Asthma or hay fever
- Yes No **g)** Fainting spells or seizures
- Yes No **h)** Persistent diarrhea or recent weight loss
- Yes No **i)** Diabetes
- Yes No **j)** Hepatitis, jaundice or liver disease
- Yes No **k)** AIDS or HIV infection
- Yes No **l)** Thyroid problems
- Yes No **m)** Respiratory problems, emphysema, bronchitis, etc.
- Yes No **n)** Arthritis or painful swollen joints
- Yes No **o)** Stomach ulcer or hyperacidity
- Yes No **p)** Kidney trouble
- Yes No **q)** Tuberculosis
- Yes No **r)** Persistent cough or cough that produces blood
- Yes No **s)** Persistent swollen glands in neck
- Yes No **t)** Low blood pressure
- Yes No **u)** Sexually transmitted disease
- Yes No **v)** Epilepsy or other neurological disease
- Yes No **w)** Problems with mental health
- Yes No **x)** Cancer
- Yes No **y)** Problems of the immune system

Yes No **8.** Have you had abnormal bleeding?
Yes No **a)** Have you ever required a blood transfusion?
Yes No **9.** Do you have any blood disorder such as anemia?
Yes No **10.** Have you ever had any treatment for a tumor or growth?

OVER

11. Are you allergic or have you had a reaction to:

Yes No **a)** Local anesthetics
Yes No **b)** Penicillin or other antibiotics
Yes No **c)** Sulfa drugs
Yes No **d)** Barbiturates, sedatives, or sleeping pills
Yes No **e)** Aspirin
Yes No **f)** Iodine
Yes No **g)** Codeine or other narcotics
Yes No **h)** Other ____________________

Yes No **12.** Have you had any serious trouble associated with any previous dental treatment?

If so, explain ____

Yes No **13.** Do you have any disease, condition, or problem not listed above that you think I should know about?

If so, explain ____

____

Yes No **14.** Are you wearing removable dental appliances?

Women

Yes No **15.** Are you pregnant?
Yes No **16.** Are you nursing?
Yes No **17.** Are you taking birth control pills?

Chief Dental Complaint ____

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

In addition, I authorize the Doctor to perform any diagnostic procedures necessary for a complete diagnosis of the patient. I also authorize the Doctor to perform any or all forms of treatment, medication and therapy that may be indicated, including the use of local anesthetic and I will assume responsibility for fees associated with those procedures. I also understand the use of any medication embodies a certain risk.

Patient/Parent Signature ______________________________ Date ______________

For completion by the dentist.

Medical/Dental Considerations ____

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Date: ______________ Signature of Dentist ______________________

Medical History Update:

Date:	Comments	Signature

Office policy concerning dental insurance

On your behalf we are pleased to submit forms for insurance claims. The amount settled by the insurance company may be altered by such factors as annual limits of coverage, non-coverage of certain procedures, etc. We encourage you to be completely familiar with the terms of your dental insurance. We accept direct settlement from insurance plans which means you will be asked to pay only that portion of the total fee estimated to be your cost - based on the information you have given us. **At all times, however, you are responsible for all costs not settled by your insurance plan.**

In the event that my insurance company accepts electronic claims, I hereby acknowledge that the claim form will be sent electronically and that payment will be made directly to the dentist. I also understand that any portion of costs not covered by insurance are my responsibility.

Patient/Parent Signature ______________________________ Date ______________