

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE SUPPLY THE DATE OF OCCURRENCE.

	DATE	YES	NO		DATE	YES	NO		DATE	YES	NO
ORGAN TRANSPLANT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL JOINTS (Hip, knee, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANY HEART CONDITION.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES TYPE 1___ TYPE 2___.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS ___ (List other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANGINA (CHEST PAIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YELLOW JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IRREGULAR HEART BEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS OR GROWTHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTERIOSCLEROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV POSITIVE TEST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS OR COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITAL HERPES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES OR FEVER BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENTAL DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OSTEOPOROSIS MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER CONDITION NOT LISTED: _____

DO YOU EVER HAVE SHORTNESS OF BREATH OR CHEST PAIN WHEN YOU WALK UP STAIRS? _____

HAVE YOU USED BISPHOSPHONATE MEDICATIONS (EXAMPLES: FOSAMAX, BONIVA, AREDIA, ZOMETA, ACTONEL)? _____

REFERRAL INFORMATION

PLEASE TELL US HOW YOU CHOSE OUR OFFICE: TV INTERNET FRIEND INSURANCE OTHER: _____


WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____


CONSENT


To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or medications, I shall inform the office staff immediately verbally and in writing.

I, the undersigned, hereby authorize this office to obtain pertinent medical information from my physician as it relates to my dental health. I also authorize this office to take any necessary x-ray images for the purpose of dental diagnosis by a doctor.

I authorize this office to obtain information on my behalf from my insurance company to determine eligibility and benefits for dental services. I also authorize this office to bill my insurance company and receive payment directly. However, I understand that insurance coverage is not guaranteed. If for any reason my insurance company does not cover or pay this office for any and all charges incurred, I, the patient, accept full responsibility and will pay my bill immediately.

 _____ I understand that I, the patient (parent / legal guardian), am fully responsible for all charges incurred in this office.
Initials

 _____ I understand that all records and x-rays are the legal property of this office and there is a fee for duplication.
Initials

 _____ I have read and agree to the OFFICE POLICIES (v. Feb. 19, 2008) received in the office or on the web site.
Initials

 _____ I have read and agree to the HIPAA PRIVACY RULES (v. Feb. 19, 2008) received in the office or on the web site.
Initials

 _____ If I so requested, I have read the NOTICE OF PRIVACY PRACTICES (v. Feb. 19, 2008) in the office or on the web.
Initials

 _____ If I so requested, I have read the DENTAL MATERIALS FACT SHEET available in the office or on the web site.
Initials

X _____ DATE _____
Signature (parent or guardian if patient is a minor)

REVIEWED BY DR. _____ DATE _____

UPDATED	
DR. _____	DATE _____
DR. _____	DATE _____
DR. _____	DATE _____
DR. _____	DATE _____