MEDICAL HISTORY:

Physician's Name _____ Date of last visit _____

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(WOMEN) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Do You pre-medicate prior to dental procedures? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ AIDS/HIV	☐ Chemotherapy	☐ Hepatitis	☐ Radiation Treatment
☐ Arthritis	☐ Steriod Treatments	Type A B C D F G	☐ Thyroid Problems
☐ Artificial Joints, Pins, Heart Valves	☐ Diabetes	☐ High Blood Pressure	☐ Tobacco Habit
☐ Asthma, COPD	☐ Epilepsy	☐ Kidney Disease	☐ Tuberculosis
☐ Back Problems	☐ Fainting or Dizziness	☐ Liver Disease	☐ Ulcer
☐ Blood Thinner	☐ Heart Murmur, MVP	☐ Pacemaker	☐ Venereal Disease
☐ Cancer	☐ Heart Attack-Stroke		

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Yes ☐ No

MEDICATION LIST:

_____

_____

_____

_____

_____

_____

ALLERGIES:

☐ Penicillin ☐ Codeine ☐ Sulfa

☐ Fluoride ☐ Dyes ☐ Latex

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES / Patient Acknowledgment

Patient Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your review of our policy by signing this form.

Patient Signature _____ Date _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

*** Please notify us if you would like a copy for your records.**

AUTHORIZATION AND RELEASE:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to 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 whether or not paid by insurance.

We reserve the right to charge for appointments cancelled or broken without a 24 hour notice. Payment is due in full at time of treatment, unless prior arrangements have been approved

Signature _____ Date _____