PLEASE PRINT CLEARLY

NAME _____ DATE OF BIRTH _____

ADDRESS _____ HOME PHONE _____

CELL PHONE _____

CITY _____ STATE _____ ZIP _____

PARENT'S NAME (IF CHILD) _____

YOUR OCCUPATION _____

COMPANY _____

BUSINESS TELEPHONE _____

PATIENT SOCIAL SECURITY # _____

INSURANCE CARRIER _____

POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S SOCIAL SECURITY # _____

SPOUSE'S NAME _____

SPOUSE'S OCCUPATION _____

TELEPHONE _____

PREVIOUS DENTIST _____

WHO REFERRED YOU TO US _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE _____ **DATE** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

** You may refuse to sign this acknowledgement**

I _____, have received a copy of this
(Print Name)
office's Notice of Privacy Practices.

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY FORM

Name: _____

Date of Birth: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Have you had any serious illness, operation or hospitalization within the past 5 years? .. Yes No
2. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills? ..... Yes No

   If so, please list _____

   _____

   _____

3. Do you smoke or use smokeless tobacco products? ..... Yes No
4. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
   d. Allergies ..... Yes No
   e. Fainting spells or seizures ..... Yes No
   f. Diabetes ..... Yes No
   g. Hepatitis, jaundice or liver disease ..... Yes No
   h. Frequent or recurring mouth sores ..... Yes No
   i. Thyroid problems ..... Yes No
   j. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   k. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   l. Stomach ulcer or hyperacidity ..... Yes No
   m. Kidney trouble ..... Yes No
   n. Tuberculosis ..... Yes No
   o. Persistent cough or cough that produces blood ..... Yes No
   p. Persistent swollen neck glands ..... Yes No
   q. Low blood pressure ..... Yes No
   r. Epilepsy or neurological disorder ..... Yes No
   s. Cancer ..... Yes No
   t. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
   u. Have you ever required a blood transfusion? ..... Yes No
5. Have you ever had treatment for a tumor or growth? ..... Yes No
6. Are you allergic to or have you had a reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics ..... Yes No
   h. Latex or rubber products ..... Yes No
   i. Other ..... Yes No
7. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy for multiple myeloma, etc.)? ..... Yes No

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 the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature _____

Date: _____ Doctor's Signature _____

Updates: _____