Patient Medical History Update

PATIENT INFORMATION

First Name		Middle Initial		Last Name			
Nickname		Gender	❑ Male ❑ Female	Birth Date		Age	
Social Security #		Driver's License #		Email			
Address		City		State		Zip Code	
Home Phone		Cell Phone					

EMERGENCY CONTACT

First Name		Last Name	
Relationship to Patient		Telephone #	

DENTAL HISTORY

Reason for today's visit			
Date of Last Dental Care		Date of Last Dental X-Rays	
How often do you floss?		How often do you brush?	

Check if you have any problems with the following:

❑ Bad Breath ❑ Bleeding Gums ❑ Periodontal Disease

❑ Clenching Mouth ❑ Grinding Teeth ❑ Sensitivity to cold, hot, sweets

MEDICAL HISTORY

Physician's Name		Date of Last Visit	
Have you had any serious illnesses or operations?			❑ Yes ❑ No
If yes, please explain			
Have you had a blood transfusion?			❑ Yes ❑ No
If yes, please explain			
Do you smoke?			❑ Yes ❑ No
If yes, please explain			
Do you consume alcohol?			❑ Yes ❑ No
If yes, please explain			
Do you use any recreational drugs?			❑ Yes ❑ No
If yes, please explain			

FOR WOMEN ONLY

Are you pregnant?	❑ Yes ❑ No	If yes, number of weeks	
Are you nursing?	❑ Yes ❑ No	Are you taking birth control pills?	❑ Yes ❑ No

Do you have, or have had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS			Chronic Sinus			Hemophilia			Radiation Treatment		
Anemia			Circulatory Problems			Hepatitis			Respiratory Disease		
Artificial Heart Valve			Cortisone Problems			High Blood Pressure			Rheumatic Fever		
Artificial Joints			Diabetes			HIV Positive			Shortness of Breath		
Asthma			Epilepsy			Jaw Pain			Sleep Apnea		
Blood Disease			Excessive Bleeding			Kidney Disease			Snoring		

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Cancer			**Fainting**			**Liver Disease**			**Tobacco Habit**		
Cerebral Palsy			**Heart Murmur**			**Mitral Valve Prolapse**			**Tuberculosis**		
Chemical Dependency			**Heart Problems**			**Nervous Problems**			**Thyroid Problems**		
Chemotherapy			**If yes, please describe**			**Pacemaker**			**Ulcers**		
CPAP Therapy						**Psychiatric Care**			**Venereal Disease**		

MEDICATIONS

List any medications you are currently taking.

ALLERGIES

List any allergies you have.

FINANCIAL POLICY

If you do not have dental insurance:

- Payment is due at the time of service.

If you do have dental insurance:

- We will accept benefits for the amount covered by the insurance company. The part not covered by the insurance company is to be paid at the end of each appointment.

Cancellation Policy:

- I understand that if I cancel any dental appointment without giving 48 hours advance notice on a business day, I will be subject to paying a $60 per hour cancellation fee.

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group 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 <u>for all charges</u> whether or not paid by insurance.

Signature of Patient, Parent or Guardian		**Date**	

** SCANNED COPY SERVES AS ORIGINAL **

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

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