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MEDICAL HISTORY

PATIENT NAME _____Birth Date _____Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	z Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Oral Health History

Previous Dentist:_____ City:_____ Phone:_____
Date of Last Check-up/X-rays:_____ Do You have a pre-medicate (take antibiotic) before dental treatment? Y - N
Does dental treatment make you nervous? Y- N Explain:_____
Are you satisfied with the appearance of you teeth? Y- N If not, what would you change?_____
Are you sensitive to: HOT, COLD, SWEETS, BITING, CHEWING, Where?_____ Do you have dental pain at this time? Y - N
How Often do you brush?_____ How often do you floss?_____
What type of toothbrush do you use?_____ Soft__ Medium__ Hard __ Electric__
Do you have, or have had, any of the following?

Y - N Bleeding ? Sore Gums	Y - N Bad Breath	Y - N Burning tongue or lips	Y - N Loose Teeth
Y - N Swollen Gums	Y - N Dry Mouth	Y - N Frequent blisters on lips / mouth	Y - N Headaches
Y - N Food Impaction	Y - N Floss Catches	Y - N Orthodontic Treatment	Y - N Mouth Breather
Y - N Uncomfortable bite	Y - N Clenching	Y - N Wisdom teeth removed	Y - N Grinding
Y - N Difficulty in jaw (clicking / popping / pain)			Y - N Head / Neck Injury

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient's General Information

Patient's Name : _____ **Date of Birth :** _____/_____/_____

If patient is minor, responsible party : _____ **Phone :** _____

Home Address : _____ **Apt :**_____ **City :** _____**Zip :** _____

Home # : _____ **Work # :** _____ **Cell # :** _____

Employer : _____ **Occupation :** _____ **Employer Address :** _____

Email : _____@_____

Status : MINOR SINGLE MARRIED LONG TERM PARTNER DIVORCED WIDOWED SEPARATED

Emergency Contact Name : _____ **Relation :** _____ **Phone # :** _____

How did you hear about us / referred by? Name _____ **Insurance Co.** __ **Dentist** __ **Web Site** ____
Other : _____

Insurance Information

Primary: Insurance Company Name / Phone

_____

_____

Insured Employer: _____

Insured Soc Sec #: _____

Group Number: _____

Secondary: Insurance Company Name / Phone:

_____

_____

Insured Employer: _____

Insured Soc Sec #: _____

Group Number: _____

As a service to you, we will complete and file your insurance claim forms for completed treatment. Please remember that insurance plans are usually not designed to pay for everything. We urge you to read your policy. We will do our utmost to see that you receive maximum benefits within the structure of your insurance plan. Your portion of payment (the costs your insurance will not cover) is due at the time of service. Accepted forms of payment include: Cash/Check, Visa, MasterCard, American Express, and Discover card.

If you have no insurance, payment for service is due at the time of treatment. To assist you we offer the following options for payment: Cash/Check, Visa or MasterCard, American Express, and Discover card.

Authorization

I authorize Dr. Afifi to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to Dr. Afifi . I authorize the use of this signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Cancellation Policy

When you make an appointment, we reserve time exclusively for you. **48 hours** notice is appreciated if you are unable to keep your appointment. We reserve the right to **charge for appointments cancelled or broken**.

Signature of Responsible Party _____ **Date** _____