# MEDICAL-DENTAL HISTORY

Patient _____ Birthdate _____ Email _____

☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced S.S.# _____ Sex _____

Home Address _____ City _____ Zip _____ Home Phone _____

Patient or Responsible Parent Employed By _____ Cell Phone _____

Business Address _____ City _____

Occupation _____ Business Phone _____

Name of Spouse _____ Occupation _____

Spouse Employed By _____ City _____

Business Address _____ Business Phone _____

Referred By _____ Do you have insurance? _____

Dentist _____ Name of Insurance Company _____

Name of Physician _____ Phone _____

Address _____

Date of Last Visit _____ Reason for Last Visit _____

Method of Payment: CASH _____ CHECK _____ VISA/MC _____ Other _____

*The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your co-operation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.*

**ALL QUESTIONS MUST BE ANSWERED**

## MEDICAL HISTORY

1. Are you in good health? _____
2. When was your last physical examination? _____
3. Are you currently under the care of a physician? If yes, for what reason or condition? _____
4. Have you been hospitalized, had a major operation or had a serious illness within the last 5 years? If yes, for what reason or condition? _____
5. Are you currently taking any medication? If yes, what medication and for what reason or condition? _____
6. Have you ever had an unusual reaction (allergic reaction) to an anesthetic or drug? (i.e., penicillin, codeine, or aspirin.) If so, what drugs or medication. _____
7. Do you wear contact lenses? _____
8. How many hours has it been since you had anything to eat or drink? _____

**HAVE YOU EVER HAD OR BEEN TREATED FOR:**

9. Rheumatic fever, rheumatic heart disease, heart murmur, congenital heart disease, heart valve replacement or mitral valve prolapse? If yes, what? _____
10. Have you had a joint replacement? (i.e., hip, knee) If yes, what? _____
11. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? If yes, what? _____
12. Abnormal blood pressure (high/low blood pressure)? _____
13. Blood disorders (excessive bleeding, anemia, etc.) If yes, what? _____
14. A stroke, convulsions, or fainting spells? _____
15. Cancer, X-ray treatments, or chemotherapy? _____
16. Tumors or growths? _____
17. Diabetes? _____
18. Hepatitis, jaundice, or liver disease? _____
19. Venereal disease, AIDS, ARC or HIV Positive? _____

**OVER ➡**

20. Breathing problems, asthma, tuberculosis, lung disease or hay fever? _____
21. Kidney problems or renal disease? _____
22. Thyroid disease? _____
23. Glaucoma? _____
24. Stomach or intestinal disease? _____
25. Have you ever had a serious injury to your head or neck? If yes, describe. _____
26. Do you have any history of sinus problems? _____
27. Have you taken any cortisone or steroids during the past year? _____
28. Have you consulted or been treated by a psychiatrist, psychologist or counselor? If yes, describe. _____
_____
29. Do you have any history of drug abuse (cocaine, heroin, etc.)? _____
30. Do you have any disease, condition, or problem not listed above that I should know about? If so, explain. _____
_____
31. Is there anything you would like to discuss with the doctor in private? _____
32. For women: Are you pregnant or is there any possibility you are pregnant? If so, how many months? _____
33. For women: Are you taking oral contraceptives? _____

## DENTAL HISTORY

Date of your last visit to a dentist _____
Reason for your last visit (or series of visits) _____
Do you have any of your x-rays or dental records? _____
IN RESPECT TO ANY PREVIOUS DENTAL TREATMENT HAVE YOU:
34. Ever fainted? _____
35. Had an allergic reaction? (Local anesthetic or any dental materials) If yes, describe. _____
_____
36. Had abnormal bleeding? _____
37. Any other complications during or following dental treatment? If yes, describe. _____
_____
38. Do you grind your teeth or clench your jaws? _____
39. Do you have pain in the jaw joint around your ear? _____
40. Do you have any history of temporo-mandibular joint (TMJ) problem? _____

NOTE: A change in your health status should be reported to the office at the earliest possible time.
To the best of my knowledge, the foregoing questions have been accurately answered.

### *FINANCIAL POLICIES AND TRUTH-IN-LENDING DISCLOSURE*

The undersigned acknowledges and agrees that the primary responsibility for any changes rendered for dental services is the primary responsibility of the undersigned, and not of any public or private insurance company or agency or the attorneys of the undersigned. I understand that the doctor's fees are their own and are in no way related to the allowable charges of any public or private insurance carrier. It is further specifically understood and agreed that if collection procedures must be instituted relative to any changes made hereunder, the undersigned will be responsible for all fees (regardless whether suit is filed or not). ALL COLLECTION COSTS, INCLUDING REASONABLE ATTORNEY'S FEES, COURT COSTS, OFFICE COSTS INCIDENT TO COLLECTION PROCEDURES IN ADDITION TO AMOUNT OWED FOR DENTAL SERVICES, TOGETHER WITH SERVICE CHARGES AT THE RATE OF 1.5% PER MONTH COMMENCING 30 DAYS AFTER FIRST BILLING. IT IS UNDERSTOOD THAT VENUE OF THIS AGREEMENT WILL BE MARTIN COUNTY, FLORIDA.

### CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dent-All Associates, Inc., (hereafter collectively referred to as "Practice") to use and disclose my entire medical record in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

Person completing this form: Signature _____ Date: _____
Print Name _____
If other than patient, indicate relationship: _____
**Doctor's Signature:** _____ **Date:** _____