WELCOME!

MEDICAL HISTORY

Max Arocha, D.M.D.
Karla Jaquez, D.M.D.
(Please print)

Patient's Name ____
Last First Middle

Address ____
Street Apt. City State Zip Code

How long at this address? ____________________ Driver's License# ____________________

Home Phone ____________________ Work Phone ____________________ **Cell Phone** ____________________

E-Mail ____

Sex __________ (M/F) Marital Status __________ SS# ____________________ Birth Date ____/______/__________

Insurance: Yes/No Insurance Company ____________________ SS# of Subscriber ____________________

Employer ____________________ Occupation ____________________ # of yrs employed __________

How were you referred to our office? ____________________

In case of emergency, please notify ____
Name Telephone Number

RESPONSIBLE PARTY

Name ____
Last First Middle

Address ____
Street Apt. City State Zip Code

Sex __________ (M/F) Marital Status __________ SS# ____________________ Birth Date __________/______/______

Cell Phone ____________________ Home Phone ____________________ Work Phone ____________________

E-Mail ____

REPRESENTATIONS

1. I understand that the information that I have given (including my medical history on page 2) is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
2. If this office accepts your insurance, I authorize payment directly to this office of any insurance benefits otherwise payable to me and I assign any and all benefits to the office, and I for paying any co-payment and deductibles that my insurance does not cover.
3. I consent to and authorize treatment recommended by the dentist and/or staff.
4. Payment is due in full at the time of treatment unless prior arrangements have been approved.
5. Appointment(s) conformation is performer via text message and/or email.

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Patient signature (parent's signature if minor or guardian) Date

Medical History

Does you medical history include any of the following?

Yes	No	
________	________	1. Are you in good health?
________	________	2. Has your health changed within the past year? ____
________	________	3. My physician's name and phone number is ____
________	________	4. Have you ever had any serious illness or operations?
________	________	5. Damaged or artificial heart valves/rheumatic fever?
________	________	6. Heart or cardiovascular disease (heart attack, angina)?
________	________	7. High or low blood pressure?
________	________	8. Abnormal bleeding?
________	________	9. Stroke?
________	________	10. Allergies to medicines or drugs? If yes, what? _______________________________________
________	________	11. Sinus trouble?
________	________	12. Fainting spells or seizures
________	________	13. Diabetes? If yes, what was your last blood sugar level? ______ Date it was last taken? _______
________	________	14. Hepatitis, jaundice or liver disease?
________	________	15. Aids or HIV Infection?
________	________	16. Thyroid Problems?
________	________	17. Respiratory problems, emphysema or bronchitis?
________	________	18. Kidney trouble?
________	________	19. Tuberculosis?
________	________	20. Sexually transmitted disease? Please explain ____
________	________	21. Cancer? Date diagnosed? Type? ____
________	________	22. Radiation treatments for cancer, tumors or growths?
________	________	23. **Do you take any bisphosphonates (i.e. Fosamax, Boniva, Aredia, Evista, Zometa, etc.)**
________	________	24. Problems with previous dental treatment?
________	________	25. Pregnant or nursing?
________	________	26. Are you taking birth control pills?
		27. List any drugs you are presently taking: ____

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NOTES: