Medical and Dental Information Update

Name ___________________________ Date of birth (dd/mm/yyyy) __________________________

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯No

Within the past year, have there been any changes in your general health? ◯ Yes ◯No

What is the date (or approx. Date) of your last medical exam? ________________________

Please check any of the following to indicate "Yes" in response to the question:

◯ Have you ever had complications following dental treatment?
◯ Are you currently under the care of a physician due to a specific condition?
◯ Have you been hospitalized within the last 5 years due to a surgery or illness?
◯ Do you use tobacco (smoking or chewing)?

If you checked any of these answers, please explain: ____
____

Please indicate if you have experienced any of the following:

◯ Allergy	◯ Artificial Joint	◯ Blood Disorder	◯ Cancer
◯ Epilepsy	◯ High Blood Pressure	◯ Heart Disease	◯ Hepatitis (A,B, or C)
◯ HIV+ (AIDS)	◯ Kidney Disease	◯ Mental Disorder	◯ Recreational Drugs
◯ Stroke	◯ Wheelchair	◯ Tuberculosis(TB)	◯ Suppressed Immune System
◯ Other Respiratory Illness(Please indicate)			

Do you have any other health issues or allergies not listed above that we should be aware of?
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Please list any prescription or non-prescription medications you are currently taking:
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What is the reason for your dental visit today? ______________________________________

When was your last visit to the dentist (if to a different office)? ________________________

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No If yes, when is the due date? ________

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from
my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.
I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature: ____ Date: _____________________

Relationship to Patient: ____