MEDICAL HISTORY

	Yes	No
1. Has there been any change in your general health within the past year?	❑	❑
Please Specify _____		
2. Are you under the care of a physician for a current problem?	❑	❑
Reason _____		
3. Have you been hospitalized within the past five years?	❑	❑
Reason _____		
4. Are you taking any medication or drugs?	❑	❑
Please specify _____		
_____		
5. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, latex or other medications?	❑	❑
6. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?	❑	❑
7. Have you ever required a blood transfusion?	❑	❑
Please explain _____		
8. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?	❑	❑
9. Have you ever been tested for HIV infection (AIDS)?	❑	❑
Results of test: Date _____ ❑ Positive ❑ Negative		
10. Date of last physician exam _____		

11. Do you have or have you ever had any of the following (please check):

❑ High blood pressure	❑ Sinus trouble
❑ Heart murmur or prolapsed valve (MVP)	❑ Thyroid problems
❑ Joint prosthesis (hip, knee, etc.)	❑ Diabetes
❑ Rheumatic fever or rheumatic heart disease	❑ Stomach ulcers, colitis
❑ Congenital heart disease	❑ Hepatitis, jaundice, liver disease
❑ Cardiovascular disease: heart attack, stroke, by-pass	❑ Alcoholism
❑ Prosthetic heart valve	❑ Kidney problems
❑ Blood disorder (e.g. anemia)	❑ Psychiatric treatment
❑ Venereal disease	❑ Fainting spells or seizures
❑ Asthma	❑ Epilepsy
❑ Temporomandibular joint problems (TMJ)	❑ Cancer

12. Do you have any disease, condition, or problem not listed above?	❑	❑
Please specify _____		
13. Are you required to take antibiotics prior to dental treatment?	❑	❑
Women:		
14. Are you pregnant, or are you nursing?	❑	❑
15. Do you take birth control pills?	❑	❑

If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

All of the above information is true to the best of my knowledge.

_____ _____

Date Signature of Patient*

*All signatures must be by parent or guardian if patient is under the age of 18.

Our office is committed to meeting or exceeding the standards of
INFECTION CONTROL mandated by OSHA, the Ohio State Dental Board and the ADA.

Responsible Party Information

Name _____ (Last / First / Middle) _____ (Marital Status)

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous address (if less than 3 years) _____ (Street / City / State / Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Whom may we thank for referring you to our office? _____

Spouses Name _____ (Last / First / Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Patient Information (If Under 18)

Patient's Name _____ Birthdate _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ❑ No ❑ If yes: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Method of Payment

Which of the following methods of payment will you be using? (Fees must be paid in full at the completion of treatment.)

Method of payment: ❑ Cash ❑ Check ❑ VISA ❑ MC ❑ Discover

All information written is true and complete. If the account is placed with an attorney and/or collection agency, all reasonable costs and/or legal fees shall be borne by the undersigned.

SIGNATURE: _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.

INITIALS: _____

Updates (date & initial): _____ _____ _____ _____

CONFIDENTIAL (for record and evaluation)