

MEDICAL HISTORY



Patient Full Name _____

Cell Phone _____

1. Are you currently experiencing pain or discomfort? YES NO
2. Do you feel very nervous about having dental treatment? YES NO
3. Have you been hospitalized in the past 2 years? YES NO
4. Have you been under a doctor's care in the past 2 years? (other than routine) YES NO
 Nature of care _____ Physician's Name _____
5. Are you currently taking any medications? YES NO
 If so, please list: _____

6. Are you allergic to or have a sensitivity to any of the following? Please check the box YES or NO next to each:
- | | | |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Sulfa | <input type="checkbox"/> <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> <input type="checkbox"/> Hydrocodone (Vicodin) |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> <input type="checkbox"/> Ibuprofen (Advil) | <input type="checkbox"/> <input type="checkbox"/> Oxycodone (Percocet) |
| <input type="checkbox"/> <input type="checkbox"/> Clindamycin | <input type="checkbox"/> <input type="checkbox"/> Lidocaine (Xylocaine) | <input type="checkbox"/> <input type="checkbox"/> Metal Allergy: type _____ |
| <input type="checkbox"/> <input type="checkbox"/> Azithromycin | <input type="checkbox"/> <input type="checkbox"/> Novacaine | <input type="checkbox"/> <input type="checkbox"/> Other: type _____ |

7. Please check the box YES or NO next to each you currently have or have had previously:
- | | | |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea/Snoring |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> <input type="checkbox"/> Epilepsy, Fainting, Dizzy Spells | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints Surgery Date _____ | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Jaw pain/Jaw Joint (TMJ) Pain | <input type="checkbox"/> <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease Type _____ | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Bisphosphonate Use (Fosamax, Reclast, Boniva) | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/Tumor Type _____ | <input type="checkbox"/> <input type="checkbox"/> Marijuana Use | <input type="checkbox"/> <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy/Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> Mental Health Disorder | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> <input type="checkbox"/> MRSA Infection | <input type="checkbox"/> <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> <input type="checkbox"/> Other: _____ |

8. Have you been advised to take antibiotics before dental treatment? YES NO

WOMEN ONLY:

Are you pregnant? YES NO month? _____

RESPONSIBLE PARTY CONSENT:

I, the undersigned certify that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I, the undersigned Hereby authorize Silverton Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time of services are rendered. I agree to pay a 1.5% per month finance charge on all accounts 60 days past due. I will give 24 hours notice if I am unable to keep an appointment. Otherwise, I am responsible for any "broken appointment" fee that may be charged.

Responsible Party Signature _____

Relationship _____

Date _____