Medical History

Please enter your medical history details

Physician Name

Physician Phone

Emergency Contact

Emergency Contact Phone

Pharmacy

Allergies Yes No

☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Dental Anesthetics
☐ ☐ Erythromycin
☐ ☐ Jewelry
☐ ☐ Latex
☐ ☐ Metals
☐ ☐ Penicillin
☐ ☐ Tetracycline

List any other allergies

Conditions Yes No

☐ ☐ Antibiotic Premedication
☐ ☐ Abnormal Bleeding
☐ ☐ Alcohol/Drug Abuse
☐ ☐ Anemia
☐ ☐ Angina/Chest Pain
☐ ☐ Arthritis
☐ ☐ Artificial Heart Valve
☐ ☐ Artificial Joints
☐ ☐ Asthma
☐ ☐ Bisphosphonates
☐ ☐ Blood Transfusion
☐ ☐ Cancer- Chemotherapy
☐ ☐ Colitis
☐ ☐ Congenital Heart Defect
☐ ☐ Cosmetic Surgery
☐ ☐ Diabetes
☐ ☐ Difficulty Breathing
☐ ☐ Emphysema
☐ ☐ Epilepsy
☐ ☐ Fainting Spells
☐ ☐ Frequent Headaches
☐ ☐ Glaucoma
☐ ☐ HIV+ AIDS
☐ ☐ Heart Attack
☐ ☐ Heart Surgery
☐ ☐ Hemophilia
☐ ☐ Hepatitis A Or B
☐ ☐ Hepatitis C
☐ ☐ High Blood Pressure
☐ ☐ Kidney Problems
☐ ☐ Leukema
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure
☐ ☐ Mitral Valve Prolapse
☐ ☐ Osteoporosis
☐ ☐ Pace Maker
☐ ☐ Pain In Jaw Joints
☐ ☐ Psychiatric Problems
☐ ☐ Radiation Therapy
☐ ☐ Rheumatic Fever
☐ ☐ Seizures
☐ ☐ Shingles
☐ ☐ Sickle Cell Disease
☐ ☐ Sinus Problems
☐ ☐ Stroke
☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis
☐ ☐ Ulcers
☐ ☐ Venereal Disease
☐ ☐ Yellow Jaundice

Do you use tobacco? Yes ☐ No ☐

For women only

Birth Control Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

If so how many weeks? 0

Nursing Yes ☐ No ☐

Please list all medications, over the counter and herbal supplements that you take

Patient's Signature

This form must be signed at the office.

For Office Use Only

Comments

Dentist's Signature

This form must be signed at the office.

Updates and Changes
It is the patient's responsibility to inform us at each appointment of any changes in medical history and/or medications. Please also inform us of any insurance, address and phone number changes at your appointments.

Appointment Policy
Our office will make every effort to confirm your appointment. If we cannot confirm your appointment, we reserve the right to reschedule your appointment. It is very important to return our calls when we are confirming your appointment. If you need to reschedule your appointment with our office, please give us twenty- four hours notice. Appointments cancelled without sufficient notice are subject to a $30.00 cancellation fee.

Insurance Policy
As a courtesy to our patients, after we have confirmed your dental insurance coverage our office will file your insurance claim directly to your insurance carrier. Keep in mind that any deductibles and co-payments are your responsibility and any co-payments quoted by our office are only estimates. Please understand that dental insurance is a contract between the patient and the insurance carrier, not between the insurance carrier and the dentist. Your employer has chosen the limits of your policy and every insurance policy is different. It is your responsibility to know the coverage and limitations of your policy. **Estimates quoted by our office are based on an average dental policy. In the event that your insurance carrier does not pay as much as we have estimated or does not pay your dental claim at all, you will be responsible for the balance due**. There are times when your insurance company will send you verification of insurance questionnaire. In that event please fill out any information they request, if this is not done your insurance company will withhold any payments and you, the patient, will be responsible for the balance. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

Payment Policy
For your convenience, our office accepts Visa, MasterCard, Discover, personal checks and cash payments. Payment is due at the time services are rendered. Patients with confirmed dental coverage are required to pay all applicable deductibles and co-payments at the time services are rendered. There are no exceptions with this office policy. Crowns and dentures require an estimated 50% co-payment at the start of the service and the remaining balance prior to cementing of crowns or delivery of dentures. Any payments not received within 15 days of billing date are considered late and are subject to a 1.5 % late fee, as well as, responsible for any collection and legal fees.
Please read this office policy and sign below stating that you understand what the policy states. If you would like a copy of this we will be glad to give you one for your records.

This form must be signed at the office.