DENTAL HISTORY

Reason for Today's Visit:_____ Date of last dental care:_____

Former Dentist:_____ Date of last dental x-rays:_____

How often do you floss:_____ How often do you brush:_____

MEDICAL HISTORY

Are you now or have you recently been under a physicians care? YES_____ NO_____ Reason:_____

Have you ever been a patient in a hospital or had any serious illness: Explain:_____

Date of Last Physical Exam:_____

CHECK any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Cancer or Tumor	☐	☐	HIV or AIDS	☐	☐	Shortness of Breath
☐	☐	High/Low Blood Pressure	☐	☐	Radiation Treatment	☐	☐	Blood Transfusion	☐	☐	Asthma or Hay Fever
☐	☐	Pacemaker	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐	Sinus Trouble
☐	☐	Rheumatic Fever	☐	☐	Lung Disease	☐	☐	Kidney Trouble	☐	☐	Glaucoma
☐	☐	Congenital Heart Problems	☐	☐	Venereal Disease	☐	☐	Arthritis	☐	☐	Epilepsy
☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐	Mental Disorder / Nervous
☐	☐	Prosthetic Joint Replacement	☐	☐	Blood Disease	☐	☐	Chest Pain	☐	☐	Anemia
☐	☐	Have you ever been told to Premedicate for the dentist?				☐	☐	Fainting / Dizzy Tendency	☐	☐	Prolonged Bleeding
☐	☐	Hepatitis: **Type A B C** (please circle)	☐	☐	Drink Alcohol	☐	☐	Cold Sore/Fever Blister	☐	☐	Smoker/Chewing Tobacco

Check any of the following that you are taking or have taken

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Anticoagulants	☐	☐	Tranquilizers	☐	☐	Cortisone Drugs	☐	☐	Osteoporosis / Bone Disease Drugs
☐	☐	Blood Thinners	☐	☐	Sedatives	☐	☐	Steroids			

Are you allergic to or do you suffer ill effects from any of the following?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Penicillin	☐	☐	Codeine	☐	☐	Dental Anesthesia	☐	☐	Other:_____
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Sulfa Drug			

Please list current Medications:

_____

_____

Women Only: Are you pregnant? ☐ Yes ☐ No If yes: How many months?_____ Are you breast feeding?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients health). It is my responsibility to inform the dental office of any changes in medical status.

OFFICE POLICIES

APPOINTMENTS: A minimum fee of $25 will be charged for broken appointments without 24 HOURS prior notification. Once an appointment is made, please remember this time is reserved for you.

INSURANCE: All professional services are charged directly to the patient. We will file necessary forms to help you obtain your benefits from insurance companies. We do not provide our services on the assumption that insurance companies will pay our fees. The patient is ultimately responsible for payment of account, regardless of payment or non-payment by the insurance company.

DELINQUENT ACCOUNTS: I do hereby agree that all dental bills are due and payble upon receipt, unless other payment arrangements have been made. Should my account become delinquent and require the services of an attorney for collection, I will pay a reasonable attorney's fee and all court costs for said collections. I also waive rights of exception under the constitution or laws of Alabama or any other state as to personal property. I understand that if my account is turned over for collections, negative information may be recorded on my credit report.

I have read and understand the above paragraphs.

Signature:_____ Date:_____

DENTAL/MEDICAL HISTORY FORM Reviewed by:_____Date:_____