Medical History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provisions of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question is related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released with out my express permission."

Patient's Initials_____ Dentist's Initials_____

To receive treatment in this office you must answer all questions on the history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office—to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of the answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

If you need additional room to answer any question please use the back of the form.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT OUR EXPRESS AND WRITTEN PERMISSION.

---

1. Name, address & phone # of your physician_____
2. Date of last visit to your doctor_____ Purpose of visit_____
3. Do you suffer from any disability? _____ If yes, describe_____
4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken? _____ **NOTE:** There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____
6. Do you now have, or have you ever had a venereal disease? _____ If yes, please describe._____
7. Have you ever had, or do you now have hepatitis? _____ If yes, please describe _____
8. For females: Are you pregnant? _____ If yes, when are you due? _____
9. For females: Are you taking birth control pills? _____ **NOTE:** There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.
10. List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each Medication:_____ _____ _____ **NOTE:** There are many drugs and medications when mixed with other drugs and/or medications that may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.
11. Have you ever had an allergic reaction to medications? _____ If yes, please describe._____
12. Have you lost weight recently? _____ If yes, describe._____

Have You Ever Had or Been Treated For:

13. Rheumatic Fever, rheumatic heart disease, heart murmur or congenital heart disease? _____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular beats? _____
15. Stomach or intestinal disease? _____
16. Abnormal blood pressure, excessive bleeding, or anemia? _____
17. Breathing problems, asthma, tuberculosis, or hay fever? _____
18. Cancer, X-ray treatments, chemotherapy, or IV biophosphonate (i.e. Zometa or Aredia) treatment? _____
19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions, or fainting spells? _____
22. Tumors or growth? _____
23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ If yes, please describe. _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, please describe. _____
26. Are you on a special diet? _____ If yes, for what reason and please describe. _____

27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ ___
    If yes, when and please describe. _____
29. Do you consume any alcoholic beverages? If yes, how much and how often? _____
30. Are there any other problems about your health of which you are aware?

    _____
31. Are you currently taking any biophosphonate medication? _____
32. Have you had any prosthetic joint replacement? _____
33. Are you allergic to latex? _____
34. Do you ever notice that your feet and/or ankles are swollen? _____
35. Are you aware of any swollen glands in your neck? _____

Dental History

1. Name of previous dentist _____ Date of last visit _____
2. Reason for your last visit (or series of visits) _____
3. Do you have any of your x-rays or dental records? _____
4. Chief dental complaint if any? _____

In respect to any previous dental treatment have you:

5. Ever fainted? _____
6. Had an allergic reaction? _____
7. Had abnormal bleeding? _____
8. Any other complications during or following dental treatment? _____
   If yes, please describe. _____
9. Do your gums bleed upon brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of you teeth becoming loose?

    _____
12. Are any of your teeth sensitive to heat, cold, or pressure? _____
13. Do you grind your teeth or clench your jaws? _____
14. Do you have pain or clicking in the jaw joint in front of your ear? _____
15. Have your jaw muscles ever been sore? _____ If yes, please describe.

    _____
16. Are there any sores or growths in your mouth? _____
17. Do any of your teeth ache? _____
18. Do you have any other dental complaints? _____
19. Are you apprehensive (nervous) about dental treatment? _____
20. Would you like to discuss sedation procedures during dental procedures? _____

21. Are there any questions you would like to ask before Dr. Leland examines your mouth?

_____

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

Patient's Initials _____ Dentist's Initials _____

Permission to Release Health Information/Authorization for Insurance Filing/Financial Responsibility of Account

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied 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). I further agree that should this account become delinquent for whatever reason, I understand that the account will be turned over to a collection agency and I will be responsible for all collection costs and/or attorney fees regarding the delinquent account.

Person completing the form: _____

Signature _____

Witness _____

Printed Name _____

If other then patient, indicate relationship _____

Date _____

Doctor Signature and Date _____