



MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Veneral Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient address _____

Patient phone number _____

I authorize Perfect Smile Dental to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Information relating to patient treatment.
2. To whom may the information be released: Patient's insurance carrier, Patient's spouse Patient's parents. Additional persons: _____
3. The purpose(s) for the release: For purposes relating to treatment and payment for services. Additional purposes: _____
4. Expiration date or event relating to the individual or purpose for the release: Open ended unless expiration date entered: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____