MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	**Have you ever had or been diagnosed with:**		
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Hernia Repair	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Special Diet/Weight Loss	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No			
Hepatitis Type _____	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No			
Herpes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No			

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Are you allergic to:

Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Other _____

Please PRINT all medications now taking: _____

_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. Graf all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. Graf (Name of Doctor Disclosing PHI) to use and/or disclose my Protected Health Information (PHI) related to dental (Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed.). The information will be used and/or disclosed for the purpose of dental (Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed.). I authorize Dr. _____ (Name of Doctor Receiving PHI) to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____