

PATIENT MEDICAL HISTORY

Today's Date: _____

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Birth Date: _____ Social Security No: _____ Marital Status: _____

Primary Dental Guarantor: _____ Phone: _____

Secondary Dental Guarantor: _____ Phone: _____

Physician Name: _____ Phone: _____

Do you smoke or use tobacco? Yes No

Sex: Male Female

If female please answer the following: Are you taking Birth Control Pills? Yes No

Are you pregnant? Yes No If Yes, number of weeks: _____

Are you nursing? Yes No

Check conditions that apply:

- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Bones
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Bruise Easily
- Cancer- Chemotherapy
- Cold Sores
- Colitis
- Congenital Heart Defect
- Cosmetic Surgery
- Cough
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Fainting Spells
- HIV+ AIDS

- Hay Fever
- Heart Attack
- Heart Defect
- Heart Failure
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Mitral Valve Prolapse
- Pace Maker
- Pain in Jaw Joints
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sickle Cell Disease
- Sinus Problems
- Sleep Apnea
- Stroke
- Taken Fen-Phen

- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease
- Yellow Jaundice
- Other: _____
- _____
- _____

Check any allergies:

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Jewelry
- Latex
- Metals
- Penicillin
- Tetracycline
- Other: _____
- _____
- _____

List all medications: _____

Is there any disease, condition or problem that this office should know about that is not covered above?

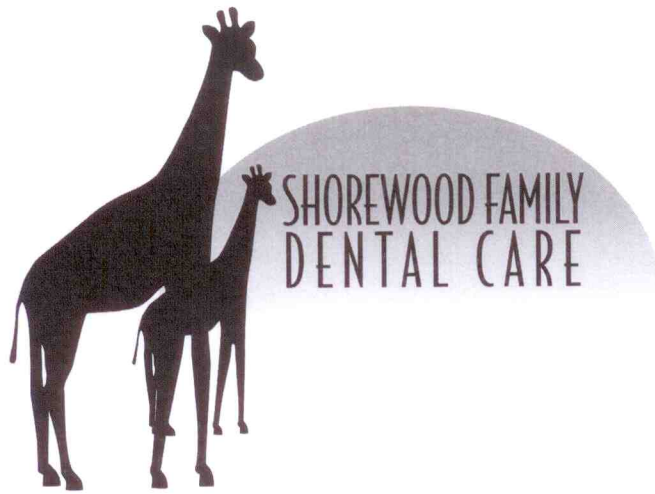
Yes No

If yes, please describe: _____

Notes: _____

Signature: _____ Date: _____

(If Under 18, Parent or Guardian Signature Required):



CONSENT

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

I authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connect with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided at Shorewood Family Dental Care for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I understand that Shorewood Family Dental Care has a cancellation policy of \$50 for any appointments that are failed or have not been cancelled within 24 hours prior to the appointment.

I understand that any treatment plan gone over with me, if insurance is involved, is an estimate only.

Patient Signature: _____ Date: _____

If Under 18, Parent or Guardian Signature Required: _____