Medical History

Name____Address____
Last First Middle Street City State Zip

Telephone (Home) _________________(Work)_________________ Sex _____ Height _____ Weight ______ Date of Birth_________________

Marital Status: Single ___Married ___ Name of Spouse ______________Occupation ____________Social Security No.____________________

Referred by________________________ In case of an emergency closest relative _______________________Telephone __________________

If you are completing this form for another person, what is your relationship to that person? ____

I. Circle Appropriate Answer: **WOULD YOU LIKE WHITER TEETH: YES ___ NO___**

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health in the last year?
3. Yes No Have you been hospitalized in the last year? Why? ____
4. Yes No Are you being treated by a physician now? For what? ____
   Date of last medical exam? _____________________________Physician's Name____________________________
   Physician's Address _______________________________________Telephone____________________________
5. Yes No Have you had problems with prior dental treatment? Date of last dental appointment?_____________________

II. Have you experienced any of the following?

6.	Yes No	Chest pain (angina?)		17.	Yes No	Dizziness?
7.	Yes No	Swollen Ankles?		18.	Yes No	Ringing in ears?
8.	Yes No	Shortness of breath?		19.	Yes No	Headaches?
9.	Yes No	Recent weight loss, fever, night sweats?		20.	Yes No	Fainting spells?
10.	Yes No	Persistent cough, coughing up blood?		21.	Yes No	Blurred Vision?
11.	Yes No	Bleeding problems, bruise easily?		22.	Yes No	Seizures?
12.	Yes No	Sinus problems?		23.	Yes No	Excessive thirst?
13.	Yes No	Difficulty swallowing?		24.	Yes No	Frequent urination?
14.	Yes No	Diarrhea, constipation, blood in stools?		25.	Yes No	Dry mouth?
15.	Yes No	Frequent vomiting or nausea?		26.	Yes No	Jaundice?
16.	Yes No	Difficulty urinating or blood in urine?		27.	Yes No	Joint pain or stiffness?

III. Do you have or have had?

28.	Yes No	Heart disease?	39.	Yes No	AIDS or ARC?
29.	Yes No	Heart attack or heart defects?	40.	Yes No	Tumors or Cancer?
30.	Yes No	Heart murmurs or Mitral Valve Prolapse?	41.	Yes No	Arthritis/rheumatism?
31.	Yes No	VD (Syphilis, Gonorrhea, Chlamydia?)	42.	Yes No	Eye disease?
32.	Yes No	Stroke or hardening of arteries?	43.	Yes No	Skin disease?
33.	Yes No	High blood pressure?	44.	Yes No	Anemia or blood disease?
34.	Yes No	TB, emphysema, asthma, lung disease?	45.	Yes No	Rheumatic fever?
35.	Yes No	Hepatitis, other liver diseases; jaundice?	46.	Yes No	Herpes?
36.	Yes No	Stomach problems, ulcers?	47.	Yes No	Kidney/Bladder disease?
37.	Yes No	**ALLERGIES**: Medications, foods, latex?	48.	Yes No	Thyroid/Adrenal disease?
38.	Yes No	Family history of diabetes, heart problems, tumors?	49.	Yes No	Diabetes?

IV. Do you have or had?

50.	Yes No	Psychiatric care?	55.	Yes No	Hospitalization?
51.	Yes No	Radiation treatments?	56.	Yes No	Blood transfusions?
52.	Yes No	Chemotherapy?	57.	Yes No	Surgeries?
53.	Yes No	Prosthetic heart valve?	58.	Yes No	Pacemaker?
54.	Yes No	Artificial joint(s)?	59.	Yes No	Contact lenses?

V. Are you taking?

60.	Yes No	Recreational drugs?	61.	Yes No	Tobacco of any form?
62.	Yes No	Drugs, medicines, (including Aspirin?)	63.	Yes No	Alcohol?

Please list medication(s)? ____

VI. Women Only:

64. Yes No Are you or could you be pregnant or nursing? 65. Yes No Taking birth control pills?

VII. All Patients:

66. Yes No Do you have any other diseases or medical problems **NOT** listed on this form? If so, please explain.

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To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication(s). I hereby authorize my name to be affixed to any documents related to my health care. This information will be used for the purpose of evaluating claims for insurance benefits. I hereby authorize payment directly to the above named office of the dental benefits otherwise payable to me and that I am responsible for all charges not paid by my dental benefit plan.

Patient's Signature (Parent or Guardian) ____ Date ______________________________

Other Side Please

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Telephone (201) 507-5000

ACKNOWLEDGEMENT OF NOTICE ON PRIVACY PRACTICES

I, ___________________________________ have read/received a copy of this office's Notice of Privacy Practices.
Please print name

____
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement receipt of our Notices of Privacy Practices, but acknowledgment could not be obtained because:

- o Individual refused to sign.
- o Communication barriers prohibited obtaining the acknowledgement.
- o An emergent situation prevented us from obtaining the acknowledgement.
- o Other (Pease specify)

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