MEDICAL HISTORY and CONSENT

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

Name: _____ DOB: _____ DATE: _____

ALLERGIES

Acrylics	Y	N
Anaphylaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pace Maker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid	Y	N

Eyes, Ears, Nose, Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Current Weight:_____lbs		
Current Height:_____		
Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip replacement	Y	N
Liver Problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Do you wear removable teeth?	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Musculoskeletal

Back pain	Y	N
Fibromyalgia	Y	N
Joint pain	Y	N
Artificial joint	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest pressure	Y	N
Congestion	Y	N
Dyspnea (shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime sleepiness Y N
Morning headaches Y N
Obstructive sleep apnea Y N
Do you use a CPAP? Y N
How often? _____
Has anyone told you that you snore? Y N

Social History

Do you smoke? Y N
_____ packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages? Y N
_____ Drinks per day/week/month
Do you use recreational drugs? Y N

List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				

List any surgeries or hospitalizations you have had:

	Date(year)	Surgery	Surgeon	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				

List and detail any medical condition or history not listed above:

_____

_____

_____

_____

_____

_____

Primary Physician's Name: _____ **Physician's Phone #:** _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Chester Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Chester Family Dentistry to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Chester Family Dentistry choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Chester Family Dentistry. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status. **FINANCIAL CONSENT:** It is my responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 ½% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Chester Family Dentistry and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult)

Name of patient _____ _____ Date _____

Signature of Patient

Consent (for a minor child)

Name of patient _____ _____ Date _____

Signature of Patient

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below, you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ **Date:** _____

Signature of Patient