

MEDICAL HISTORY

Date: _____

Name of person completing this section (if different than patient) and relationship to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION:

- 1. Are you in good health? Y N
- 2. Has there been any change in your general health in the past year? Y N
- 3. Date of last check up by physician: _____
- 4. Are you currently under a physician's care? Y N
If so, what for? _____

Treating physician's name: _____ Phone number: _____

- 5. Have you had any serious illness, operations, or hospitalization?
If so, describe and give approximate dates: _____

- 6. Have you ever had intravenous sedation or general anesthesia? Y N
Were there any adverse effects? Y N
- 7. Do you generally tolerate dental treatment well? Y N
- 8. DO YOU HAVE OR HAVE YOU EVER HAD:
 - A. Heart disease that was detected at birth? Y N
 - B. Rheumatic fever or Rheumatic heart disease? Y N
 - C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? Y N
 - D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? Y N
 - E. Neurologic disorders (seizures, epilepsy, fainting, dizziness, nervous disorder)? Y N
 - F. Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? Y N
 - G. Liver disease (jaundice, hepatitis)? Y N
 - H. Kidney disease? Y N
 - I. Diabetes? Y N
 - J. Thyroid disease? Y N
 - K. Arthritis? (which joints?) Y N
 - L. Stomach ulcers or intestinal problems? Y N
 - M. Glaucoma? Y N
 - N. Frequent or recurring mouth sores? Y N
 - O. Implants/artificial joints anywhere in the body? (heart valve, hip, knee)? Y N
 - P. Radiation therapy (X-ray treatment for cancer) in head or neck region? Y N
 - Q. Noises in jaw joint, pain near ear when chewing, or do you grind or clench your teeth? Y N
 - R. Sinus or nasal problems? Y N
 - S. Any disease, drug, or transplant operation that has depressed your immune system? Y N
 - T. Recurrent infections of any kind? Y N

- 9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:
 - A. Antibiotics? Y N
 - B. Anticoagulants (blood thinners or aspirin)? Y N
 - C. Thyroid medications? Y N
 - D. Antihistamines, decongestants? Y N
 - E. High blood pressure or heart medication? Y N
 - F. Steroids? Y N
 - G. Tranquilizers, antidepressants? Y N
 - H. Stomach or GI medications (antacids, etc.)? Y N
 - I. Cholesterol reducing drugs? Y N
 - J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain reliever? Y N
 - K. Weight reduction pills or diet aids (OTC or "natural" products)? Y N
 - L. Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? Y N
 - M. Marijuana, cocaine, or other "recreational" drugs? Y N
 - N. Any other regular medications, pills, supplements, or drugs? Y N

PLEASE LIST ALL CURRENT MEDICATIONS/DRUGS/SUPPLEMENTS ("YES" ON 9A - 9N) HERE:

RELEASE

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE, INCLUDING X-RAYS.

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE, AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS.

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE, AND TREATMENT TO ANOTHER DENTIST.

I AUTHORIZE PHOTOGRAPHS TO BE TAKEN, INTRAORALLY AND EXTRAORALLY. I AUTHORIZE USE OF THESE PHOTOGRAPHS BY THE DENTIST WITHIN THE PRACTICE, AS WELL AS EXTERNALLY, FOR EDUCATIONAL PURPOSES AND/OR CASE PRESENTATIONS.

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO MARY SWIFT DDS, P.A. DBA DALLAS LASER DENTISTRY. IF THE INSURANCE COMPANY MISTAKENLY REIMBURSES ME, I AM RESPONSIBLE FOR SIGNING ANY REIMBURSEMENT OVER TO MARY SWIFT DDS, P.A.

I UNDERSTAND THAT MY DENTAL CARE INSURANCE CARRIER OR PAYOR OF MY DENTAL BENEFITS MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR PAYMENTS IN FULL OF ALL ACCOUNTS. BY SIGNING THIS STATEMENT, I REVOKE ALL PREVIOUS AGREEMENTS TO THE CONTRARY AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES NOT PAID, IN WHOLE OR PART, BY MY DENTAL CARE PAYOR OR GUARANTOR.

PATIENT/PARENT(GUARDIAN) _____ **DATE:** _____

ACCOUNT GUARANTOR (IF DIFFERENT) _____ **DATE:** _____

How Did You Hear About Us?

- ◆ Web site: _____ Which one? _____
 - ◆ Internet Search Engine _____ Which one? _____ What keyword(s)? _____
 - ◆ Mailing _____
 - ◆ Insurance Company List _____ Name of Insurance Company _____
 - ◆ Someone's Recommendation _____
If yes, who can we thank: _____
 - ◆ Other _____
- What was the primary reason you chose to come to us versus another dental office? _____
