MEDICAL CONDITION/HISTORY

Date _____ Home Phone_____
Patient? _____
First Name Last Name Middle Initial Preferred Name
Street Adreess_____City_____State_____Zip_____
E mail_____Cell Phone _____
Sex ___ F ____ M Age _____Birthdate_____ Married _____ Widowed_____Single_____Minor_____
Separated_____Divorced_____Partnered For_____years

Employer /School_____ Occupation_____
Employer /School Address_____ Employer /School Phone_____
Spouse/Parent Name_____ Spouse/Parent Birthdate_____
Spouse/Parent Employed by_____-_____ Occupation_____
Business Address_____ Bussiness Phone _____
Who is responsible for this account?_____ Relationship to Patient_____
Social Security #_____ Spouse/Parent's Social Security #_____
Name of Dental Insurance Company_____ Group Number_____
In case of emergency, who should be noticed_____ _____
_____ Phone_____
Whom may we thank for referring you?_____ _____
_____ _____

MEDICAL HISTORIAL

Physician's Name_____ Date of Last Physical_____
Have you ever had any of the following? (check boxes that apply):

- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints, Screws, etc
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Hernia Repair
- ☐ High Bood Pressure
- ☐ HIV/AIDS
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Physician Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Ulcer
- ☐ Veneral Desease

Doy you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia?
yes _____ No_____ I so, what?_____
Have you ever responded adversely to medical or dental treatment? Yes _____ No_____
Are you taking any medication at this time?_____ If so, what? _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of loni-min, Adipez, Fastin (brand names of phentermine), Pondimin (fenfiuramine) and Reduz (dexfenfluramine) yes___No____
Are you under the care of a physician? Yes_____ No_____ For what conditions? _____
If patient is a child, what is his / her weight?_____
(Women) Do you suspect that you are pregnant? Yes_____ No_____ Due Date? _____
Are you Nursing? Yes _____ No _____ Taking birth control Pills? Yes _____ No _____
Is there anything else we should know about your medical history?_____
_____

clay-dental

MEDICAL CONDITION/HISTORY

To the best of my knowledge, the information provided on this form complete and correct. I understand that it is my responsability to inform my doctor if my minor child ever has a change in heath.

MINOR / CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor / child
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform neccessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not Iam present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent (s) is covered by insurance with _____
Name of Insurance Company (ies)
And assign directly to Dr._____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 name-named doctor may use my minor/child's 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 determing insurance benefits or the benefits payable for releated services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of mino /child.
I understand that filing a claim with my insurance company does not relieve me form my responsability for payment of all charges.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please Print name of Parent, Guardian or Personal Representative — Relationship to Patient

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment ? Yes _____ No_____
For what conditions?_____
Is the patient taking any new medications?_____ If so, what?_____

_____ _____
Date — Patient Signature

_____ _____
Date — Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment ? Yes _____ No_____
For what conditions?_____
Is the patient taking any new medications?_____ If so, what?_____

_____ _____
Date — Patient Signature

_____ _____
Date — Dentist Signature