

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Name of your current physician Yes No If yes _____

Surgical Operations

Appendectomy <input type="radio"/> Yes <input type="radio"/> No	Back <input type="radio"/> Yes <input type="radio"/> No	Ear <input type="radio"/> Yes <input type="radio"/> No	Gallbladder <input type="radio"/> Yes <input type="radio"/> No
Heart <input type="radio"/> Yes <input type="radio"/> No	Hernia repair <input type="radio"/> Yes <input type="radio"/> No	Lung <input type="radio"/> Yes <input type="radio"/> No	Nasal <input type="radio"/> Yes <input type="radio"/> No
Thyroid <input type="radio"/> Yes <input type="radio"/> No	Tonsillectomy <input type="radio"/> Yes <input type="radio"/> No	Uvullectomy <input type="radio"/> Yes <input type="radio"/> No	Periodontal <input type="radio"/> Yes <input type="radio"/> No

Other: Yes No If yes _____

Family History

Has any member of your family (parent, sibling, or grandparent) had:

Cancer <input type="radio"/> Yes <input type="radio"/> No	Heart disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	High blood pressure <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No	Sleep disorder <input type="radio"/> Yes <input type="radio"/> No	Obesity <input type="radio"/> Yes <input type="radio"/> No	Thyroid disorder <input type="radio"/> Yes <input type="radio"/> No
Father snores <input type="radio"/> Yes <input type="radio"/> No	Mother snores <input type="radio"/> Yes <input type="radio"/> No	Father has sleep apnea <input type="radio"/> Yes <input type="radio"/> No	Mother has sleep apnea <input type="radio"/> Yes <input type="radio"/> No

Social History

Are you a tobacco user of one of the following:

Cigarettes <input type="radio"/> Yes <input type="radio"/> No	Pipe <input type="radio"/> Yes <input type="radio"/> No	Cigar <input type="radio"/> Yes <input type="radio"/> No	Snuff <input type="radio"/> Yes <input type="radio"/> No
Chew <input type="radio"/> Yes <input type="radio"/> No	Never used <input type="radio"/> Yes <input type="radio"/> No		

Currently smoking? How many packs a day? Yes No If yes _____

Quit smoking? When did you quit? Yes No If yes _____

Caffeine Intake:

none <input type="radio"/> Yes <input type="radio"/> No	Coffee <input type="radio"/> Yes <input type="radio"/> No	Tea <input type="radio"/> Yes <input type="radio"/> No	Soda <input type="radio"/> Yes <input type="radio"/> No
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Drink Caffeine? How much do you drink daily? Yes No If yes _____

Do you drink alcohol? # of drinks per week? Yes No If yes _____

Do you exercise? How often? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Do you have any allergens to the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfu Drugs	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Sleeping pills	<input type="checkbox"/> No known allergens

Other: If yes _____

Are you currently taking any medication? List: Yes No

(NAME/DOSE/WHY?)

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Corticone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No	Angina <input type="radio"/> Yes <input type="radio"/> No
Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No
High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No
Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No
Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No
Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No
Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Add reflux <input type="radio"/> Yes <input type="radio"/> No	Atherosclerosis <input type="radio"/> Yes <input type="radio"/> No	Bleed Easily <input type="radio"/> Yes <input type="radio"/> No
Chronic fatigue <input type="radio"/> Yes <input type="radio"/> No	Chronic Pain <input type="radio"/> Yes <input type="radio"/> No	COPD <input type="radio"/> Yes <input type="radio"/> No	Coronary heart disease <input type="radio"/> Yes <input type="radio"/> No
Depression <input type="radio"/> Yes <input type="radio"/> No	Difficulty sleeping <input type="radio"/> Yes <input type="radio"/> No	Daytime Sleepness <input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia <input type="radio"/> Yes <input type="radio"/> No
Immune system disorder <input type="radio"/> Yes <input type="radio"/> No	Insomnia <input type="radio"/> Yes <input type="radio"/> No	Ischemic heart disease <input type="radio"/> Yes <input type="radio"/> No	Mood Disorder <input type="radio"/> Yes <input type="radio"/> No
Multiple sclerosis <input type="radio"/> Yes <input type="radio"/> No	Nasal allergies <input type="radio"/> Yes <input type="radio"/> No	Neuralgia <input type="radio"/> Yes <input type="radio"/> No	Osteoarthritis <input type="radio"/> Yes <input type="radio"/> No
Parkinson's disease <input type="radio"/> Yes <input type="radio"/> No	Prior Orthodontics <input type="radio"/> Yes <input type="radio"/> No	Rheumatic arthritis <input type="radio"/> Yes <input type="radio"/> No	Sleep apnea <input type="radio"/> Yes <input type="radio"/> No

If you marked "YES" please list below: Current Status and Date of Diagnosis Yes No

Do you have any other Medical Condition not listed above? Yes No

Please list below with Current status and Date of Diagnosis

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

DISHONORED FEE: Matthews Dental charges a \$25 fee for any check or credit card that is dishonored for any reason.

PERMISSION TO CONTACT I grant my permission to Matthews Dental or assignee to telephone me at home, at my workplace, or on my cell phone to discuss matters related to this form. I agree to allow text messages with pertinent information to be texted to my personal cell phone number. I also agree to allow the office to leave voice mails concerning appoints and/or results. I also agree information may be left with a family member in the event I am not available, and someone else answers the number I have provided for this office to use to contact me.

48 HOUR CANCELLATION POLICY Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise. The office reserves the right to charge \$50 per hour scheduled as a fee for any appointment that is missed/cancelled without giving the business 48 hours notice. This decision is at the discretion of the office.

SAFETY For the safety of yourself and our other patients no one is allowed in the operatory room throughout the course of your treatment. This includes both children and adults. We have a waiting room available for family members not being treated.

This agreement supersedes all prior signed agreements, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior agreements related to financial agreements or quality of care are null and void.

I acknowledge that I have received a copy of this office's PRIVACY POLICIES. I agree to disclose to the dentist the names of any individuals with whom I GIVE MY PERMISSION TO DISCUSS MY DENTAL CARE.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND. I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREIN.

Signature of Patient, parent or guardian

Date

Please print name of patient _____