

# HEALTH HISTORY

Date of last medical exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: \_\_\_\_\_

Are you currently under a physician's care? No Yes If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list any medications you are currently taking and dosages:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? \_\_\_\_\_ When did the treatment end? \_\_\_\_\_

Are you currently taking any blood thinners? NO YES Which Drug: \_\_\_\_\_

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

- |                                  |    |     |                                 |    |     |
|----------------------------------|----|-----|---------------------------------|----|-----|
| a. Local anesthetics             | No | Yes | d. Codeine, Valium or sedatives | No | Yes |
| b. Penicillin                    | No | Yes | e. Latex or Metals              | No | Yes |
| c. Aspirin, Ibuprofen or Tylenol | No | Yes | f. Other (please specify) _____ |    |     |

***For the following questions circle yes or no.***

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature: \_\_\_\_\_

Welcome to Deak Medical Dentistry

Please take a few moments to complete this form in its entirety. All information will be considered confidential, and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.

**MUST FILL OUT ALL THE INFORMATION FULLY.**

**PATIENT INFORMATION** Date \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Sex  M  F Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ \* Social Security number \_\_\_\_\_  
MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Marital Status (check one)  Minor  Single  Married  Divorced  Widowed  Separated

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**MUST BE UPDATED EACH YEAR WITH ALL INFORMATION**

**DENTAL INSURANCE INFORMATION**

Insurance Holder's Name \_\_\_\_\_ Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Holder's date of birth \_\_\_\_\_ Insurance Holder's social security number \_\_\_\_\_

Insurance Company \_\_\_\_\_

\*The proceeding information will be on your dental insurance card.

Member ID \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company phone number \_\_\_\_\_

**FEDERAL EMPLOYEE'S ONLY**

**MEDICAL INSURANCE INFORMATION**

Insurance Holder's Name \_\_\_\_\_ Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_

Insured's holder date of birth \_\_\_\_\_ Insurance Holder's social security \_\_\_\_\_

Insurance company \_\_\_\_\_

\*The proceeding information will be on your medical card

Member ID \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company phone number \_\_\_\_\_

**\*We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.**

**Assignment of benefits to physician:** I authorize the release of medical or other information necessary to process health insurance claims on my behalf. I also request payment of benefits to Deak Medical Dentistry when assignment of benefits is accepted.

**Consent to treat:** I, the undersigned, authorize medical treatment for **myself** or my minor child, \_\_\_\_\_, as deemed necessary and provided by Dr. Deak and Deak Medical Dentistry

**I have read and understand the privacy policy for the office of Deak Medical Dentistry \_\_\_\_\_.**

PATIENT PRINTED NAME: \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_