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
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals 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: _____