MEDICAL HISTORY

Name ______________________________ Date of Birth ______________________

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please list: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________
Are you on a special diet? ◯ Yes ◯ No ______________________
Do you use tobacco? ◯ Yes ◯ No ______________________
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________________

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

AIDS/HIV Positive ◯
Alzheimer's Disease ◯
Anaphylaxis ◯
Anemia ◯
Angina Arthritis/Gout ◯
Artificial Heart Valve ◯
Artificial Joint ◯
Asthma ◯
Blood Disease ◯
Blood Transfusion ◯
Breathing Problem ◯
Bruise Easily ◯
Cancer ◯
Chemotherapy ◯
Chest Pains ◯
Cold Sores/Fever Blisters ◯
Congenital Heart Disorder ◯
Convulsions ◯

Cortisone Medicine ◯
Diabetes ◯
Drug Addiction ◯
Easily Winded ◯
Emphysema ◯
Epilepsy or Seizures ◯
Excessive Bleeding ◯
Excessive Thirst ◯
Fainting Spells/Dizziness ◯
Frequent Cough ◯
Frequent Diarrhea ◯
Frequent Headaches ◯
Genital Herpes ◯
Glaucoma ◯
Hay Fever ◯
Heart Attack/Failure ◯
Heart Murmur Heart ◯
Pace Maker Heart ◯
Trouble/Disease ◯

Hemophilia ◯
Hepatitis A ◯
Hepatitis B or C ◯
Herpes ◯
High Blood Pressure ◯
Hives or Rash ◯
Hypoglycemia ◯
Irregular Heartbeat ◯
Kidney Problems ◯
Leukemia ◯
Liver Disease ◯
Low Blood Pressure ◯
Lung Disease ◯
Mitral Valve Prolapse ◯
Pain in Jaw Joints ◯
Parathyroid Disease ◯
Psychiatric Care ◯
Radiation Treatments ◯
Recent Weight Loss ◯

Renal Dialysis ◯
Rheumatic Fever ◯
Rheumatism ◯
Scarlet Fever ◯
Shingles ◯
Sickle Cell Disease ◯
Sinus Trouble Spina Bifida ◯
Stomach/Intestinal Disease ◯
Stroke ◯
Swelling of Limbs ◯
Thyroid Disease ◯
Tonsillitis ◯
Tuberculosis ◯
Tumors or Growths ◯
Ulcers ◯
Venereal Disease ◯
Yellow Jaundice ◯

Have you ever had any serious illness not listed above? ◯ Yes If yes, please explain: ______________________

Have you ever taken or are you taking Bone Growth Medication (ex. Boniva)? ◯ Yes ◯ No

Comments: ____
____
____
____

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 ______________________ DATE ____________

PATIENT REGISTRATION

First Name: ______________________ Last Name: ______________________ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: ______________________

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ______________________ Last Name: ______________________ Middle Initial: ____

Address: ______________________ Address 2: ______________________

City, State, Zip: ______________________ Pager: ______________________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Birth Date: ____________ Soc Sec: ____________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ______________________ Address 2: ______________________

City: ______________________ State / Zip: ______ ____________ Pager: ______________________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ____________ Age: ______ Soc. Sec: ____________

E-mail: ______________________

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Referred by: ______________________

Employer ID: ______________________ Pref. Pharmacy: ______________________

Carrier ID: ______________________

Section 3

Spouse's name: ______________________

Spouse's phone #: ______________________

Primary Insurance Information

Name of Insured: ______________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ______________________

Address: ______________________

Address 2: ______________________

City,State,Zip: ______________________

Ins. Company: ______________________

Address: ______________________

Address 2: ______________________

City,State,Zip: ______________________

Secondary Insurance Information

Name of Insured: ______________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ______________________

Address: ______________________

Address 2: ______________________

City,State,Zip: ______________________

Ins. Company: ______________________

Address: ______________________

Address 2: ______________________

City,State,Zip: ______________________

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Margaret Garcia, DDS, Inc.. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Margaret Garcia, DDS, Inc. reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ YES	☐ NO
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (Parents, Grandchildren)	☐ YES	☐ NO
Other: ______________________________	☐ YES	☐ NO
Name of patient (please print): ______________________________		
Patient signature: ______________________________		
Patient's personal representative: (Please Print): ____________________		
Personal Representative's signature: ______________________________		
Representative's Telephone Number: ______________ **Date:** ______________		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** __________
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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