5 MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name : ______________________

Phone #: (____)______________ Date of last visit: ____________

Your current physical health is: ❑ Poor ❑ Fair ❑ Good

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: ______________________

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

Please list each one: ______________________

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #:_______

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Respiratory Problems
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Veneral Disease

Please list any medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Codeine
Y N Latex
Y N Other
Y N Dental Anesthetics
Y N Penicillin
Y N Jewelry/Metals

Please list any other drugs that you are allergic to: ____________

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In the event of an emergency, we need the name of someone who does not live with you who we can contact.

His /Her Name:______________________Relation: _______

Wk #: (____)________________Hm #: (____) __________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I accept full responsibility for charges incurred as a result of dental treatment and agree to pay any legal fees or court costs associated with collecting any balance due. I understand finance charges are applied to any outstanding balance.

____

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

! **Thank you for filling out this form completely. It will enable us to more effectively help you. If you have a question at any time, please ask us. We are happy to help.**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Lorena M. Surber DDS, PLLC
1218 Virginia St., East
Suite A
Charleston, WV 25301 :01

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I verbally reviewed the medical / dental information above with the patient named herein.

Initials:__________ Date: ______________________

Doctor's comments: ______________________

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