Drs. Thompson & Dunn Dentistry

CONSENT TO RELEASE MEDICAL OR BILLING INFORMATION, ACKNOWLEDGMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I hereby authorize Drs. Thompson & Dunn to release medical, dental, and billing information on my behalf to the following person(s). I have also received a copy of this office's Notice of Privacy Practices. I also give you permission to leave any pertinent medical or appointment information on my answering machine or cell phone.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Patient or Guardian Signature	Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)

Medical History Form

Date _____

Name _____

Home Phone (____)_____ Work Phone (____)_____

Address _____ City _____

State _____ Zip _____ Occupation _____

Social Security # ☐☐☐-☐☐-☐☐☐☐ Date of Birth ___/___/___ Height _____ Weight _____

☐ Male ☐ Female ☐ Single ☐ Married Name of Spouse _____

Closest Relative _____ Relation _____ Phone (____)_____

If you are completing this form for another person, what is your relationship to that person? _____

Who were you referred by? _____

Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... ☐ Yes ☐ No
2. Has there been any change in your general health within the past year?..... ☐ Yes ☐ No
3. My last physical examination was on: _____
4. Are you now under the care of a physician? ..... ☐ Yes ☐ No

What condition are you being treated for? _____

5. The name and address of my physician(s) is: _____
4. Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... ☐ Yes ☐ No

If so, what was the illness or problem? _____

7.Are you taking any medication(s) including non-prescription?..... ☐ Yes ☐ No

If so, what medication(s)? _____

8. Do you have or have you had any of the following diseases or problems?
   - Damaged heart valves or artificial heart valves, including heart murmur or rheumatic disease. ..... ☐ Yes ☐ No
   - Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... ☐ Yes ☐ No
   - Do you have chest pain upon exertion? ..... ☐ Yes ☐ No
   - Are you ever short of breath after mild exertion or when lying down? ..... ☐ Yes ☐ No
   - Do your ankles swell? ..... ☐ Yes ☐ No
   - Do you have inborn heart defects? ..... ☐ Yes ☐ No
   - Do you have a cardiac pacemaker? ..... ☐ Yes ☐ No
   - Allergies..... ☐ Yes ☐ No
   - Sinus Trouble..... ☐ Yes ☐ No
   - Asthma or hay fever ..... ☐ Yes ☐ No
   - Fainting spells or seizures ..... ☐ Yes ☐ No

Persistent diarrhea or recent weight loss ..... ☐ Yes ☐ No
Diabetes ..... ☐ Yes ☐ No
Hepatitis, jaundice or liver disease ..... ☐ Yes ☐ No
AIDS or HIV infection..... ☐ Yes ☐ No
Thyroid problems..... ☐ Yes ☐ No
Respiratory problems, emphysema, bronchitis, etc. ..... ☐ Yes ☐ No
Arthritis or painful swollen joints ..... ☐ Yes ☐ No
Stomach ulcer or hyperacidity..... ☐ Yes ☐ No
Kidney trouble..... ☐ Yes ☐ No
Tuberculosis..... ☐ Yes ☐ No
Persistent cough or cough that produces blood..... ☐ Yes ☐ No
Persistent swollen glands in neck ..... ☐ Yes ☐ No
Low blood pressure ..... ☐ Yes ☐ No

Sexually transmitted disease ☐ Yes ☐ No
Epilepsy or other neurological disease ☐ Yes ☐ No
Problems with mental health ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Problems of the immune system ☐ Yes ☐ No
Have you had abnormal bleeding? ☐ Yes ☐ No
a. Have you ever required a blood transfusion? ☐ Yes ☐ No
10. Do you have any blood disorder such as anemia? ☐ Yes ☐ No
11. Have you ever had any treatment for a tumor or growth? ☐ Yes ☐ No
12. Are you allergic or have you had a reaction to:
☐ Local anesthetics ☐ Penicillin or other antibiotics ☐ Sulfa drugs ☐ Iodine
☐ Barbiturates, sedatives, or sleeping pills ☐ Aspirin ☐ Codeine or other narcotics ☐ Other

13. Have you had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

If so, explain_____

14. Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Yes ☐ No

If so, explain_____

15. Are you wearing contact lenses? ☐ Yes ☐ No
16. Are you wearing removable dental appliances? ☐ Yes ☐ No

Women

17. Are you pregnant? ☐ Yes ☐ No
18. Do you have any problems associated with your menstrual period? ☐ Yes ☐ No
19. Are you nursing? ☐ Yes ☐ No
20. Are you taking birth control pills? ☐ Yes ☐ No

Chief Dental Complaint_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Patient Signature

For completion by the dentist.

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

_____ _____
Date Signature of Dentist

Medical history updated:

Date	Comments	Signature