MEDICAL/ DENTAL HISTORY

Name____Birth Date_____________________

Name of Physcian(Medical Doctor)_____________________________date of last visit_____________

Physcian's address____

WELCOME! We are pleased to welcome you to our practice .The following information is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate in formation is necessary to safely and efficiently protect your health. Incorrect informaiton can be dangerous to you and compromise our ability to provide appropriate and healthful dental care. if you have any questions, we will be happy to help!

General

- Are you in good general health? ____

- Any change in your health in the past year? yes, no / reason____________________________________

- Are you under the care of a physician? yes, no / reason____

- Date of last physical?____

- Have you been hospitalized or had a serious illness or major operation?______________________________

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Systems Review

Please Circle conditions you have had in the past or currently have.

Cardiovascular System

Mitral valve prolapse, heart murmur, valve dysfunction, rheumatic fever, rheumatic heart disease

Previous bacterial endocarditis, artificial heart valve, systemic pulmonary shunt, cogential heart defect

Heart disease, heart failure, chest pain, heart attack, date____________, heart surgery, date______________

Pacemaker, replaced artery, date_________, High blood pressure, low blood pressure, arrhythmia

Circulatory problems in the body, circulatory problems in the head or neck, bypass surgery in the body

Cerebrovascular accident (stroke), fainting spells, other____

Hematopoietic (blood coagulation disorders)

Excessive bleeding, hemophillia, clotting problems____

Respiratory System

Lung disease, persistant cough or cold, bronchitis, tuberculosis, emphysema, pneumonia,

Shortness of breath, asthma, chronic sinus problems, seasonal allergies (hay fever)

Digestive System

Stomach ulcers / acid reflux, chronic indigestion, diarrhea, jaundice, liver disease, hepatitis A, B, or C

Genitourinary System

Kidney disease / failure, renal dialysis, kidney transplant

Sexually transmitted diseases, AIDS, ARC, HIV, herpes virus

Skeletal System (bones / joints)

Arthritis, swollen joints, inflammatory rheumatism, osteoporosis

Artificial joint(s): hip, knee or other joint, date placed ____

Neuro/ physchological conditions

Fainting spells, seizures, frequent headaches, epilepsy, paralysis, Alzheimers disease

Multiple Sclerosis, Parkinsons, clinical depression or anxiety, psychiatric treatment

Drug dependence, substance abuse, alcohol, tobacco use, other___________________________________

Endocrine System

Frequent thrist, frequent urination, thyroid disease: hypoththyroidism, hyperthyroidism

Diabetes controlled/ uncontrolled, if yes: **Type I,** insulin dependent or **Type II**, adult onset

Multiple System

Cancer, cancer treatment, treatment for tumor or growths, radiation, chemotherapy

Organ transplant, immunosuppressant therapy, cortisone treatment

Have you had any other condition or disease not previously mentioned?________________________________

Women-Pregnancy/ Menopause

Are you pregnant?__________, How many months?___________, Nursing?________________________

Are you taking birth control medication(s)?____

Are you taking hormone replacement?____

I have reviewed the information on this questionare and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Givan and his staff to help determine appropiate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Givan.
I authorize my insurance company to pay Dr. Givan all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I aurthorize Dr Givan to release all information necessary to secure the payment of benefits.I also understand that I am fully financially responsible for all charges whether covered, not covered or declined by my insurance company, I understand that proper dental decisions are made between the patient and the Dentist, and not the insurance company. I understand that since treatment plans are explained and decisions are made mutually before treatment is begun, I give my consent to perform any needed dental treatment, including the use of local anesthetics as needed. (I also give consent for the use of photographs for patient education purposes: agree / disagree)

Signature of patient,
parent or legal guardian ____**date**___________