Tampa Dental
Medical History

Patient's Name ____ **Today's Date** __________________________

Physician's Name ____ **Date of last visit** __________________________________

Have you had any serious illness or operations? _________ **Describe** ____

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Have you ever had a blood transfusion? ______________ **If yes, give approximate dates** ______________________________________

Have you had a joint replacement? ____

(Women) Are you pregnant? ? Yes ? No Nursing? ? Yes ? No Taking Birth control pills? ? Yes ? No

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<u>Check (v) if you have had any of the following:</u>

? AIDS
? Anemia
? Arthritis, Rheumatism
? Artificial Heart Valves
? Artificial Joints
? Asthma
? Back Problems
? Blood Disease
? Cancer
? Chemical Dependency
? Chemotherapy
? Circulatory Problems
? HIV Positive
? Cough, Persistent
? Cough up Blood
? Diabetes
? Epilepsy
? Fainting
? Glaucoma
? Headaches
? Heart Murmur
? Heart Problems
Describe ______________
? Hemophilia
? Hepatitis
? High Blood Pressure
? Jaw Pain
? Cortisone treatments
? Kidney Disease
? Liver Disease
? Mitral Valve Prolapse
? Nervous Problems
? Pacemaker
? Psychiatric Care
? Radiation Treatments
? Respiratory Disease
? Rheumatic Fever
? Scarlet Fever
? Skin Rash
? Shortness of Breath
? Stroke
? Swelling of feet/ankles
? Thyroid Problems
? Tobacco Habit
? Tonsillitis
? Tuberculosis
? Ulcer
? Venereal Disease

Are you currently taking HRT, or Fosomax, Boniva or other Bisphosphonates? (please list)___________________________________

List medications you are currently taking (over the counter and prescription) ____

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Pharmacy Name _____________________________ **Location** _____________________________ **Phone #** _______________________

<u>Do You Have Allergies to?</u> ? Aspirin ? Penicillin ? Barbiturates (sleeping pills) ? Sulfa ? Codeine ? Local Anesthetic

? Latex ? Foods (please list)____

Other Allergies: ____

(Form Revised July, 2009)

Tampa Dental

RESPONSIBILITY AND CONSENT

I hereby authorize and request the performance of dental services for myself or my minor child. I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or the supervised staff for diagnostic purposes or dental treatment.

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Date: **Signature of patient or Parent/guardian if patient is a minor**

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned have insurance with ____

Name of insurance company(ies)

and assign directly to Tampa Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage. I have provided Tampa Dental with all information necessary to secure the payment of benefits. Additionally, I authorize the release of any information relating to this claim and authorize the use of this signature for all my insurance claims whether manual or electronic.

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Date: **Signature of Patient/insured person**

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, including any percentages not covered by my insurance carrier. I understand that in the event I default in my payment for said services I can be charged an amount to cover collection or attorney fees.

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Date: **Signature of patient or parent/guardian**

(Form Revised July, 2009)