

# Medical History

Your Name \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illness or operations? \_\_\_\_\_ Describe \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ If yes, give approximate dates \_\_\_\_\_

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

## Check (✓) if you have had any of the following:

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

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

Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_ Phone # \_\_\_\_\_

Allergies to:  Aspirin  Penicillin  Barbiturates (sleeping pills)  Sulfa  Codeine  Local Anesthetic  Other \_\_\_\_\_

## 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.

\_\_\_\_\_  
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 will all the 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.

\_\_\_\_\_  
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.

\_\_\_\_\_  
Signature of patient or parent/guardian