

MEDICAL HISTORY – Drs. Mathias, Olson & Worthington

Patient Name _____ **Birthdate** _____
Mailing Address _____ **City** _____
Occupation _____
Home Phone _____ **Cell Phone** _____ **Email** _____
How would you like to receive appointment confirmations? By phone, text or email? _____
Emergency Contact & Relationship _____ **Phone #** _____

Although dental personnel generally treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you receive. Thank you for answering these questions.

Going to the dentist is:
 Pleasant Not too bad Difficult, but I do ok Terrifying

Do you have any specific concerns today? _____

How long has it been since your last dental exam and/or cleaning? _____

Is there anything you would like to change about the appearance of your smile? _____

Who is your primary care provider? Name & phone _____

Are you currently under a physician's care for treatment? _____

Have you ever been hospitalized or had a major operation? _____

Have you ever had a serious head or neck injury? If so, when? _____

Are you taking any medications or supplements? Please list: _____

Has your physician told you that you need to pre-medicate prior to dental appointments? _____

Do you pre-medicate before dental appointments for dental anxiety? _____

Do you take, or have you taken Phen-Fen or Redux? _____

Do you take, or have you taken bisphosphonates (Fosamax, Reclast, Boniva, Zometa)? _____

Are you on a special diet? _____

Do you use tobacco? If yes, how long and frequency? _____

Smoking Chewing Vaping

Do you use controlled substances? What and how often? _____

Are you: Pregnant/Trying to get pregnant? A nursing mother? Taking oral contraceptives?

Circle any of the following you are allergic to, OR check this box if there are no known allergies

- | | | | |
|---------------|-----------------------|-----------|------------------------|
| Acetaminophen | Barbiturates/Sedative | Ibuprofen | Local Anesthetics |
| Acrylic | Bee stings | Iodine | Metals |
| Aspirin | Codeine/Narcotics | Latex | Penicillin/Amoxicillin |
| | | | Sulfa Drugs |

Other: _____ Please fill out back page! 

Please check if you have or have had any of the following?

- | | | |
|----------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Easily Winded | <input type="radio"/> Mitral Valve Prolapse |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Emphysema | <input type="radio"/> Multiple Sclerosis |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Osteopenia |
| <input type="radio"/> Anemia | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Angina | <input type="radio"/> Excessive Thirst | <input type="radio"/> Pain in Jaw Joints |
| <input type="radio"/> Arthritis | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Parathyroid Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Frequent Cough | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Frequent Headaches | <input type="radio"/> Post-Traumatic Stress Disorder (PTSD) |
| Joint(s) _____ | <input type="radio"/> Glaucoma | <input type="radio"/> Psychiatric Care _____ |
| Year _____ | <input type="radio"/> Gout | <input type="radio"/> Radiation Treatments |
| <input type="radio"/> Acid Reflux/GERD | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Recent Weight Loss |
| <input type="radio"/> Asthma (as adult?) | <input type="radio"/> Heart Murmur | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Blood Disease | <input type="radio"/> Heart Pacemaker | <input type="radio"/> Rheumatism |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Shingles |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Hemophilia | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hepatitis (A,B, or C) | <input type="radio"/> Sinus Trouble |
| Type _____ | <input type="radio"/> Herpes | <input type="radio"/> Sleep Apnea |
| Year _____ | <input type="radio"/> High Blood Pressure | <input type="radio"/> Stomach/ Intestinal Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> High Cholesterol | <input type="radio"/> Stroke |
| <input type="radio"/> Chest Pains | <input type="radio"/> Hives or Rash | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> COPD | <input type="radio"/> Hypoglycemia | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Ulcers |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Kidney Problems | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> Cortisone Medicine | <input type="radio"/> Leukemia | <input type="radio"/> Other _____ |
| <input type="radio"/> Dementia | <input type="radio"/> Liver Disease | |
| <input type="radio"/> Diabetes (Type I or Type II) | <input type="radio"/> Low Blood Pressure | |
| <input type="radio"/> Drug Addiction | <input type="radio"/> Lung Disease | |
| Active? ____ Type? ____ | <input type="radio"/> Memory Issues | |

Comments:

Financial Policy

- Payment is due at time of service. A 5% discount is given to patients who pay this way.
- We reserve time in our schedule just for you; missed appointments are very expensive for us. We will charge \$100 for each hour of missed appointment time. We require 24 hours notice (not including the weekend) if you need to cancel an appointment.
- The Uptown Dental Clinic may run a personal credit report if payment is not made at time of service and an extension of credit is considered. Any outstanding balance over 60 days will accrue an interest charge at the rate of 1% per month. Any account that is not in compliance with the financial policy may be considered for collections.

Please check one:

- I will pay at time of service.
- I have insurance and will pay the balance after insurance pays their portion.

Permit for treatment and surgical care: I hereby give my permission to the staff of the Uptown Dental Clinic to employ such treatments and therapy as may be deemed professionally necessary or advisable. For most dental procedures, local anesthetic is administered. Risks involved may include: heart palpitations, allergic reaction, hematoma, paresthesia and/or drug cross-reaction. Plaster study models, x-rays, and/or photographs may be released for professional review and may be forwarded to other dentists.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. My signature indicates understanding and acceptance of this entire agreement:

Signature of patient, parent or guardian: X _____ Date: _____