MEDICAL HISTORY – Drs. Mathias and Olson

Patient Name _____ **Birthdate**_____
Street 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:
O Pleasant O Not too bad O Difficult, but I do ok O 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? _____
O Smoking O Chewing O Vaping

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

Are you: O Pregnant/Trying to get pregnant? O A nursing mother? O 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?

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

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 $60 for each hour of missed confirmed appointment time. Please give us 24 hours notice 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:

- O I will pay at time of service.
- O 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:_____