MEDICAL HISTORY

Silverton FAMILY DENTISTRY

Patient Full Name _____

Cell Phone _____

1. Are you currently experiencing pain or discomfort? ..... [Y] YES [N] NO
2. Do you feel very nervous about having dental treatment? ..... [Y] YES [N] NO
3. Have you been hospitalized in the past 2 years? ..... [Y] YES [N] NO
4. Have you been under a doctor's care in the past 2 years? (other than routine) ..... [Y] YES [N] NO

   Nature of care _____ Physician's Name _____
5. Are you currently taking any medications? ..... [Y] YES [N] NO

   If so, please list: _____
6. Are you currently taking Blood Thinners? ..... [Y] YES [N] NO

7. Are you allergic to or have a sensitivity to any of the following? **Please Check the Box** [Y] YES or [N] NO next to **EACH**:

[Y][N] Sulfa	[Y][N] Acetaminophen (Tylenol)	[Y][N] Hydrocodone (Vicodin)
[Y][N] Penicillin/Amoxicillin	[Y][N] Ibuprofen (Advil)	[Y][N] Oxycodone (Percocet)
[Y][N] Clindamycin	[Y][N] Lidocaine (Xylocaine)	[Y][N] Metal Allergy: Type_____
[Y][N] Erythromycin	[Y][N] Novacaine	[Y][N] Other: Type_____

8. **Please Check the Box** [Y] YES or [N] NO next to **EACH** you currently have or have had previously:

[Y][N] Acid Reflux/GERD	[Y][N] Eating Disorder	[Y][N] Sleep Apnea
[Y][N] Alzheimer's/Dementia	[Y][N] Epilepsy	[Y][N] Snoring
[Y][N] Anemia	[Y][N] Fainting/Dizzy Spells	[Y][N] Stroke
[Y][N] Arthritis	[Y][N] Hemophilia	[Y][N] Thyroid Problems
[Y][N] Artificial Joints – Surgery Date _____ Type _____	[Y][N] Hepatitis Type _____	[Y][N] Tobacco Use
[Y][N] Asthma	[Y][N] HIV/AIDS	[Y][N] Tuberculosis
[Y][N] Autoimmune Disease Type _____	[Y][N] Jaw pain/Jaw Joint (TMJ) Pain	[Y][N] Heart Disease
[Y][N] Bisphophonate Use (Fosemax, Reclast, Boniva)	[Y][N] Kidney Disease	[Y][N] High Blood Pressure
[Y][N] Cancer/Tumor Type _____	[Y][N] Liver Disease	[Y][N] Angina Pectoris
[Y][N] Chemotherapy/Radiation Therapy	[Y][N] Marijuana Use	[Y][N] Heart Attack
[Y][N] Cold Sores/Fever Blisters	[Y][N] Mental Health Disorder	[Y][N] Congenital Heart Defect
[Y][N] Diabetes I or II	[Y][N] MRSA Infection	[Y][N] Pacemaker
[Y][N] Insulin Pump	[Y][N] Osteoporosis	[Y][N] Artificial Heart Valve
[Y][N] Drug/Alcohol Addiction	[Y][N] Respiratory Problems	[Y][N] Other:_____

8. Have you been advised to take antibiotics before dental treatment? ..... [Y] YES [N] NO

WOMEN ONLY

Are you pregnant? [Y] YES [N] NO Month? _____

RESPONSIBLE PARTY CONSENT

I, the undersigned certify that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I, the undersigned Hereby authorize Silverton Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time of services are rendered. I agree to pay a 1.5% per month finance charge on all accounts 60 days past due. I will give 24 hours notice if I am unable to keep an appointment. Otherwise, I am responsible for any "broken appointment" fee that may be charged.

_____ _____ _____

Responsible Party Signature Relationship Date