SEUBERT FAMILY DENTISTRY

PATIENT NAME:_____ Birthdate:_____

Address:_____ Phone Number:_____

Email Address:_____

MEDICAL HISTORY UPDATE

Physician's Name:_____ Phone Number:_____

Address:_____ Date of last visit_____

Circle to indicate if you have any of the following conditions that may require premedication for dental treatment:

Joint replacement(s) **Mitral valve prolapse** **Artificial heart valve** **Infective endocarditis**

Have you ever used a bisphosphonate medication? Common brands- Fosamax, Actonel, Atelvia, Didronel, Boniva Y N

Do you currently or have you ever used tobacco products? _____

Have you had any serious illnesses, communicable diseases, operations, or hospitalizations? Y N

If yes, describe_____

_____

Please circle to indicate if you have had any of the following:

Anemia	**Chemical Dependency**	**High Blood Pressure**	**Shortness of Breath**
Arthritis, Rheumatism	**Chemotherapy**	**Hepatitis**	**History of Stroke**
Artificial Heart Valve	**Cough, Persistent**	**HIV/ARC/AIDS**	**Swelling of Feet or Ankles**
Artificial Joints/Implants	**Diabetes: Current A1c: _____**	**Kidney Disease**	**Thyroid Disease**
Asthma	**Epilepsy**	**Mitral Valve Prolapse**	**Tobacco/Cigarette Use**
Back Problems	**Fainting**	**Pacemaker**	**Tuberculosis**
Bleeding Abnormality	**Glaucoma Transplant**	**Radiation Treatment**	**Tumors**
Blood Disease	**Heart Murmur**	**Respiratory Disease**	**Ulcers**
Cancer	**Heart Disease/Surgery**	**Rheumatic Fever**	**Venereal Disease/STI**

List Medications you are currently taking and why:

_____

_____

_____

_____

_____

ALLERGIES?

Penicillin _____ Codeine_____ Local Anesthetic_____

OTHER:_____

_____

Are you currently taking blood thinning medication? Y N

_____

(WOMEN) Are you pregnant? Y N Nursing? Y N Taking Birth Control Pills? Y N

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in medical or oral health.

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
(Insurance Company)

SEUBERT FAMILY DENTISTRY, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist/dental office may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent is effective today until the date I provide written withdrawal of consent.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

Payment is due in full at time of dental treatment unless prior arrangements have been approved.

THANK YOU FOR TRUSTING US WITH YOUR DENTAL CARE