PATIENT MEDICAL HISTORY AND INFORMATION

Patient's Name | Sex | Date of Birth | Social Security No. | Marital Status

Address | City | State | Zip | Spouse's Name

Employer & Address, City, State, Zip | Dental Ins. Co. | Group No.

Email Address | Home Phone | Cell Phone | Work Phone

Physician Name and Number | Name & Number to Contact in Case of an Emergency

Name & Number of Nearest Relative Not Living in your Household

Do you have any of the following allergies?

Y	N		Y	N	
◻	◻	Aspirin	◻	◻	Latex
◻	◻	Codeine	◻	◻	Metals
◻	◻	Dental Anesthetics	◻	◻	Penicillin
◻	◻	Erythromycin	◻	◻	Tetracycline
◻	◻	Jewelry	◻	◻	Other____________________

Please answer the following:

Y	N	
◻	◻	Do you smoke or use tobacco?
◻	◻	If you are female: are you taking Birth Control Pills?
◻	◻	Are you pregnant? If yes, # of weeks ____
◻	◻	Are you nursing?

Have you ever taken any of these medications?

Fosamax, Zometa, Aredia, Skelid, Bonefos, Actonel, Boniva, Didronel, Alendronate, Prolia, Xgeva

Please List all Medications:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

Do any of the following conditions apply?

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Hemophilia
☐	☐	Alcohol Abuse	☐	☐	Hepatitis B or C
☐	☐	Anemia	☐	☐	High Blood Pressure
☐	☐	Anesthetic Reactions	☐	☐	Joint Replacements
☐	☐	Angina Pectoris	☐	☐	Kidney Problems
☐	☐	Artificial Heart Valve	☐	☐	Liver Disease
☐	☐	Asthma	☐	☐	Loss of Hearing
☐	☐	Bacterial Endocarditis	☐	☐	Loss of Sight
☐	☐	Blood Transfusion	☐	☐	Low Blood Pressure
☐	☐	Cancer-Chemotherapy	☐	☐	Migraines
☐	☐	Chronic Pain Medication	☐	☐	Multiple Sclerosis
☐	☐	Congential Heart Defect	☐	☐	Osteoporosis
☐	☐	Congestive Heart Failure	☐	☐	Pacemaker/Internal Defibrillator
☐	☐	Diabetes			
☐	☐	Difficulty Breathing	☐	☐	Psychiatric Problems
☐	☐	Drug Abuse	☐	☐	Pulmonary (Lung)Disease
☐	☐	Emphysema	☐	☐	Radiation Therapy
☐	☐	Epilepsy	☐	☐	Rheumatic Fever
☐	☐	Fainting Spells/Seizures	☐	☐	Shingles/Herpes
☐	☐	Fosamax, Zometa, Aredia, Skelid, Boniva, Bonefos Actonel, Alendronate, Didronel, Prolia, Xgeva	☐	☐	Sickle Cell Disease
			☐	☐	Sinus/Hay Fever
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	HIV+ AIDS	☐	☐	Throat Disease/Hoarseness
☐	☐	Heart Attack	☐	☐	Thyroid Disease (Hyper/Hypo)
☐	☐	Heart Surgery	☐	☐	Tuberculosis
			☐	☐	Ulcers/Colitis

Is there any disease, condition, or problem that you think this office should know about that is not covered above? ______________________________

FINANCIAL STATEMENT

Our office accepts all dental insurances (except for Medicare and Medicaid) and we participate with the Assurant, Ameritas, Guardian, Cigna Dental PPO, United Concordia, and Delta Dental Premier insurance companies. As a courtesy we will submit your dental claim to your insurance company.

We do require that you pay your portion that is not covered by the insurance company at the time of service. We gladly accept cash, checks, Visa, MasterCard, Discover, and American Express.

We have financing available and will be happy to go over any details at the front desk.

In the event that the patient's portion goes unpaid and/or is turned over to collections, the patient will be responsible for any and all collection fees, 1.5% interest per month will be incurred to all balances 90 days past due regardless of collection status, and you will be responsible for any attorney and court cost.

For those using a credit card you authorize Elkton Family Dentistry to charge your credit card for balances due for services rendered that your insurance company identifies as your financial responsibility. This authorization relates to <u>all</u> payments <u>not</u> covered by your insurance company for services provided to you by Elkton Family Dentistry. Your credit card information is kept confidential and secure.

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Signature (If under 18, Parent or Guardian Signature Required) Date