Family Dental Care of Milford, Prof. Assn.

William A. Green, DMD K. Drew Wilson, DMD Joshua T. Osofsky, DMD

Patient Medical History – Personal and Confidential

Patient Name ____ **Date of Birth** ________________

1. Are you in good health? Yes _____No _____ If No, explain ____

2. Are you under a physician's care now? Yes _____No _____ If yes, explain ____

3. Are you taking any pills or medications now? Yes _____No _____ If yes, list ____

4. Are you a smoker? Yes______ No____

5. Name of your medical doctor ____________________________Phone Number________________Town_____________________

6. Have you had any allergic or unusual reaction to an anesthetic or drug (like Penicillin)? Yes _____No _____

7. Have you stayed overnight in the hospital in the last 5 years? Yes _____No ___
If yes, when? _____________For what reason? ____

8. Have you ever had any trouble with prolonged bleeding after surgery? Yes _____No _____

9. Please indicate which of the following you have at present or have had in the past: Circle "Yes" or "No" on each item.

Heart attack	Yes	No
Heart disease	Yes	No
Angina pectoris	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
Heart valve problem	Yes	No
Heart surgery	Yes	No
Rheumatic fever	Yes	No
Arthritis	Yes	No
Drug addiction	Yes	No
Stroke	Yes	No
Anemia	Yes	No

Kidney trouble	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Thyroid problem	Yes	No
Emphysema	Yes	No
Asthma	Yes	No
Allergies or Hives	Yes	No
Sinus trouble	Yes	No
Chemotherapy	Yes	No
Radiation therapy	Yes	No
____Artificial Joints__	_Yes_	__No
Latex allergy	Yes	No

Hepatitis	Yes	No
A.I.D.S.	Yes	No
H.I.V. positive	Yes	No
Blood transfusion	Yes	No
Bleeding problems	Yes	No
Bruise easily	Yes	No
Epilepsy/seizures	Yes	No
Fainting/dizzy spell	Yes	No
Nervousness	Yes	No
Psychiatric treatment	Yes	No
Cold sore/Fever blister	Yes	No
Periodontal (gum surgery)	Yes	No

10. Do you have any disease, condition or problem not listed? Yes _____ No _____ If yes, explain ______________________________

11. Did your medical doctor ever say you had cancer or a tumor? Yes _____ No _____

12. Are you allergic to any type of jewelry or metal? Yes _____ No _____

13: **For women only**: Are you pregnant? Yes _____ No _____ Are you nursing? Yes _____ No _____

Are you taking birth control pills? Yes _____ No _____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions truthfully and to the best of my knowledge.

Patient signature ____ Date ________ Staff ____________
(Parent or Guardian if Minor)

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CONSENT:
The undersigned hereby authorizes employees of Family Dental Care of Milford, Prof. Assn. to take x-rays, 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 therapies that may be indicated in connection with (name of patient) _______________ and further authorize and consent that Doctor choose and employ such assistance as deemed 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 the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness and such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

Patient signature ____ Date _________________ Staff ______________
(Parent or Guardian if Minor)

Responsible party (financial) signature ____ Relationship to patient ____________________________