MEDICAL AND PERSONAL HISTORY

Date: ________________

CONFIDENTIAL

Please Print

Patient's Name: Ms., Mrs., Mr., Dr., ______________________________ Birth Date: ______________ Sex: ______
Person responsible for account: ______________________________ **Home Phone:** ________________
Residence Address: ______________________________ Zip: ________________
E-mail: ____________________ Cell Phone: ______________ Soc. Sec. #: ________________
Name of Business: ❑ Spouse or ❑ Self ______________________________
Business Address: ______________________________ Work Phone: ________________
Patient's Physician: ______________________________ City: ________________
Who referred you to this office? ______________________________ General Dentist: ________________
In case of emergency, please call ______________________________ Relationship to Patient: ____________
Dental Insurance Carrier: ________________ ID #: ______________ Grp #: ________________
History of Trauma: (Circle One)
Is the present problem due to an accidental injury .... Yes No
How and when did the accident occur? ______________________________

HEALTH HISTORY Has the patient had or ever been told (he, she) has had:

1. An allergic reaction to any drugs? If yes - list: ______________________________ Yes No
2. A reaction to an anesthetic injection ("novocain")? .... Yes No
3. Stomach problems/Ulcers? .... Yes No
4. A history of taking any diet drugs or dietary supplements (Fen Fen, St. John's wort)? .... Yes No
5. Rheumatic fever, heart murmur, or Mitral Valve Prolapse? .... Yes No
6. High Blood Pressure or history of heart disease? .... Yes No
7. Diabetes? .... Yes No
8. Slow healing of wound or incision? .... Yes No
9. Excessive or prolonged bleeding? .... Yes No
10. Hepatitis or Liver Disease? .... Yes No
11. Venereal Disease? .... Yes No
12. Epilepsy? .... Yes No
13. AIDS or exposure to people with HIV? .... Yes No
14. Is there any other information about your health we should know? .... Yes No
____
____
15. If female, are you pregnant? .... Yes No
16. Most recent medications .... Yes No
    If yes - list: ______________________________
    ____
17. What have you ever been hospitalized for, and when? ______________________________
____

FINANCIAL RESPONSIBILITY

We will be glad to provide you with our Master Bill Claim Form which you may file with your insurance carrier, **SO THAT YOU CAN BE REIMBURSED BY YOUR INSURANCE COMPANY.** If payment is inadvertently made to us by your insurance company, the insurance check will be immediately mailed to you **PROVIDING ALL FEES FOR DENTAL SERVICES HAVE BEEN PAID.**

YOU ARE FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED and **FULL PAYMENT TO THE DOCTOR IS EXPECTED AT THE TIME SERVICES ARE RENDERED.** We accept cash, check or credit cards (Visa, MasterCard or Discover).

I also understand the **PERMANENT (FINAL) RESTORATION** (filling, inlay, post or crown, etc.) will be done by my **GENERAL DENTIST.**

HIPAA Privacy Acknowledgement: I have received a copy of Drs. Delany & Moiseiwitsch P.C. Notice of Privacy Procedures. By signing below I authorize my digital health records to be forwarded to my Referring Dentist or any other health care provider who is providing medical or dental care for me.

Signature of PATIENT or ______________________________ Signature of DENTIST ______________________________
Parental permission (if patient is under 21)