

Patient Name _____

Medical Alert _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____
Physician's Name _____ Phone _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medications, drugs or pills now? Yes No
If yes, please list name and dosage _____
4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
If yes, please list _____
5. Have you been a patient in the hospital during the past five years? Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	AIDS	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	HIV Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusions	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medication	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list: _____
8. Women: Are you: Pregnant? Yes or No / ___ Months
Nursing? Yes or No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you will have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____



PATIENT INFORMATION			
Date			
Name			
Spouse			
Address			
City		State	Zip
Home Phone No.		Mobile Phone No.	
Birthdate		Age	
Married	Single	Divorced	Widowed
Social Security No.		Drivers License No.	



DENTAL INSURANCE	
PRIMARY CARRIER	
Insurance Company	
Employee	
Group No.	
Emp. Birthdate	
Emp. Social Security No.	
Date Employed	
SECONDARY CARRIER	
Insurance Company	
Employee	
Group No.	
Emp. Birthdate	
Emp Social Security No.	
Date Employed	



ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
Name	
Address	
City	State Zip
Home Phone No.	Work Phone No.
Your Name	
Occupation	
Employer	
Business Address	City
Business Telephone	Ext.
YOUR SPOUSE	
Name	
Occupation	
Employer	
Business Address	City
Business Telephone	Ext.



GETTING TO KNOW YOU	
Is Another Member of your Family or a Relative a Patient at our Office?	
Their Name	
Referred to us by:	
Person to Contact for Emergency	
Phone No.	
Address	
City	State Zip
Closest Relative not living with you	
Phone No.	
Address	
City	State Zip

I acknowledge that a copy of Dr. Linville's Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability and Accountability Act of 1996

(HIPAA) _____ Sign _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to Dr. Linville of Dental Benefits, if any, otherwise payable to me _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Linville to release any information acquired in the course of my examination or treatment to specific insurance carriers involved in processing and collection of this claim _____