Chart #_____
(For Office use only)

Cedar Springs Dental Medical History

NAME: Mr./Master/Mrs./Ms./Miss./Dr. (Circle one)

_____

DOB: _____
ADDRESS:

_____

_____

_____Postal Code_____

PHONE: _____

Cell Phone: _____

E-mail: _____
Please Check box if you would like emailed reminders.

Business Phone: _____

Occupation: _____

Who referred you to our office?
_____

In case of Emergency, we should notify:

NAME:_____

RELATIONSHIP:_____

DAY-TIME PHONE:_____

Are you nervous during dental treatment? Yes☐ No☐

FAMILY DOCTOR: _____

PHONE: _____

PHARMACY: _____

PHONE: _____

FAX: _____

DRIVERS LICENSE#:_____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so why? Yes☐ No☐ Not sure☐

_____

2. When was your last Family Doctor medical checkup? _____
3. When was your last dental visit? _____
4. Has there been any change in your general health in the past year? If yes, please explain.
Yes☐ No☐ Not sure☐

_____

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
List of Medications: _____ _____
_____ _____
_____ _____

_____

6. Do you have any allergies? If you answered yes, please list using the categories below:
Yes☐ No☐ Not sure☐

a) Medications e.g. penicillin, sulfa
b) latex/rubber products
c) other e.g. hayfever, food

_____

7. Have you ever had an adverse reaction to any medicines or injections? If yes, please explain.
Yes☐ No☐ Not sure☐

_____

8. Do you have or have you ever had asthma? Yes☐ No☐ Not sure☐

_____

9. Do you have or have you ever had any heart/blood pressure problems? Yes☐ No☐ Not sure☐

10. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever, heart valve replacement? Please Circle.

11. Do you have a prosthetic or artificial joint? Yes☐ No☐ Not sure☐

12. Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes☐ No☐ Not sure☐

13. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes☐ No☐ Not sure☐

14. Have you ever had hepatitis, jaundice or liver disease? Yes☐ No☐ Not sure☐

15. Do you have a bleeding problem or bleeding disorder? Yes☐ No☐ Not sure☐

16. Have you ever been hospitalized for any illness or operations? If yes please explain. Yes☐ No☐ Not sure☐

17. Do you have or have you ever had any of the following? Please check.

arthritis	heart attack	shortness of breath
cancer	kidney disease	steroid therapy
chest pain	lung disease	stomach ulcers
diabetes	pacemaker	stroke
diet pill therapy	prosthetic heart valve	thyroid disease
drug/alcohol dependency	seizures (epilepsy)	tuberculosis

18. Are there any conditions/diseases not listed above that you have or have had? If so, what? Yes☐ No☐ Not sure☐

19. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) Yes☐ No☐ Not sure☐

20. Do you smoke or chew tobacco products? Yes☐ No☐ Not sure☐

21. **For Women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? Yes☐ No☐ Not sure☐

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. To the best of my knowledge the above information is correct

Signature of patient, parent or guardian: _____ Date:_____