PATIENT MEDICAL HISTORY

Patient's Name________________ Date________________
Date of Birth________________ Sex________________ Physician's Name________________
Height______ ft ______ inches Weight________________ Address________________
Have there been any problems in your general health (serious illness, hospitalization, surgery, etc.)?________________ City________________
State________________ Zip________
Phone #________________

1. Are you happy with the appearance of your teeth? .... YES NO
2. Are you having pain or discomfort at this time? .... YES NO
3. Do you feel very nervous about having dental treatment? .... YES NO
4. Have you ever had a bad experience in the dental office? .... YES NO
5. Have you been a patient in the hospital during the past two years? .... YES NO
6. Have you been under the care of a medical doctor during the past two years? .... YES NO
7. Have you taken any medicine or drugs during the past two years? .... YES NO
8. Are you now taking any medication, drugs or pills? .... YES NO
   If yes, please list:________________
9. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .... YES NO
   If yes, please list:________________ Latex Allergy? YES NO
10. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES NO	Emphysema	YES NO	Hepatitis A, B or C	YES NO
Heart Disease or Attack	YES NO	Cough (Chronic)	YES NO	Infectious or Serum	YES NO
Angina Pectoris	YES NO	Tuberculosis (TB)	YES NO	Liver Disease	YES NO
High Blood Pressure	YES NO	Asthma	YES NO	Yellow Jaundice	YES NO
Heart Murmur	YES NO	Hay Fever	YES NO	Blood Transfusion	YES NO
Rheumatic Fever	YES NO	Sinus Trouble	YES NO	Drug Addiction	YES NO
Congenital Heart Lesions	YES NO	Allergies or Hives	YES NO	Hemophilia	YES NO
Scarlet Fever	YES NO	Diabetes	YES NO	Venereal Disease	
Artificial Heart Valve	YES NO	Thyroid Disease	YES NO	(Syphilis, Gonorrhea)	YES NO
Heart Pacemaker	YES NO	X-ray or Cobalt Treatment	YES NO	Cold Sores	YES NO
Heart Surgery	YES NO	Chemotherapy (Cancer, Leukemia)	YES NO	Fever Blisters	YES NO
Artificial Joints (Hip, Knee)	YES NO	Arthritis	YES NO	Epilepsy or Seizures	YES NO
Anemia	YES NO	Rheumatism	YES NO	Fainting or Dizzy Spells	YES NO
Stroke	YES NO	Cortisone Medicine	YES NO	Nervousness	YES NO
Kidney Trouble	YES NO	Glaucoma	YES NO	Psychiatric Treatment	YES NO
Ulcers	YES NO	Pain in Jaw Joints	YES NO	Sickle Cell Disease	YES NO
Cosmetic Surgery	YES NO	H.I.V. Positive	YES NO	Bruise Easily	YES NO

11. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? .... YES NO
12. Do your ankles swell during the day? .... YES NO
13. Do you use more than 2 pillows? .... YES NO
14. Have you lost or gained 10 pounds in the past year? .... YES NO
15. Do you ever wake up from sleep short of breath? .... YES NO
16. Are you on a special diet? .... YES NO .... Have you taken Fen-Phen? YES NO
17. Has your medical doctor ever said you have a cancer or a tumor? .... YES NO
18. Do you have any disease, condition, or problem not listed? .... YES NO
19. Are you pregnant? YES NO If yes, what month?________ Are you taking birth control pills? YES NO
20. TMJ Screening

Headaches	YES NO
Ear Aches	YES NO
Neck Problems	YES NO
Facial Pain	YES NO
Sore Joints	YES NO
Locking Jaw	YES NO
Ear Stuffiness	YES NO
Tinnitus (Ringing in the Ear)	YES NO
Sinus Pain	YES NO
Sleep Problems	YES NO
Snoring	YES NO

21. Children and Adolescents
   Does your child have a favorite nick-name? ....________
   Is this your child's first treatment visit in a dental office? .... YES NO
   Does your child have a finger sucking habit? .... YES NO
   Is your child involved in any of the following programs:
   - Speech Therapy? .... YES NO
   - Special Education? .... YES NO
   - Physically Handicapped? .... YES NO

   Have this child's teeth been treated with Topical Fluorides? .... YES NO
22. I understand 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 ____/____/____

PERSONAL INFORMATION:

PATIENT:

Name______________________________

Spouse, if any______________________________

Address______________________________

City____________________ State_______ Zip_______

Home Phone (   )______________________________

Date of Birth ______/______/______ Age__________

_____Married _____Single _____Divorced _____Widowed

Social Security No. __ __ __ - __ __ - __ __ __ __

E-mail Address______________________________

Cell Phone Number (   )______________________________

Employer______________________________

Address______________________________

City____________________ State_______ Zip_______

Phone (   )____________________ Ext._______

Occupation______________________________

PARENT/RESPONSIBLE PARTY:

Name______________________________

Spouse, if any______________________________

Address______________________________

City____________________ State_______ Zip_______

Home Phone (   )______________________________

Date of Birth ______/______/______ Age__________

Social Security No. __ __ __ - __ __ - __ __ __ __

Relationship to Patient______________________________

Employer______________________________

Address______________________________

City____________________ State_______ Zip_______

Phone (   )____________________ Ext._______

Occupation______________________________

DENTAL INSURANCE (PRIMARY):

Insurance Company______________________________

Address______________________________

City____________________ State_______ Zip_______

Phone (   )______________________________

Group No.______________ Union/Local No.__________

Employee/Insured______________________________

Employee S.S. No. __ __ __ - __ __ - __ __ __ __

Employee Date of Birth ______/______/______

DENTAL INSURANCE (SECONDARY):

Insurance Company______________________________

Address______________________________

City____________________ State_______ Zip_______

Phone (   )______________________________

Group No.______________ Union/Local No.__________

Employee/Insured______________________________

Employee S.S. No. __ __ __ - __ __ - __ __ __ __

Employee Date of Birth ______/______/______

HEALTH (MEDICAL) INSURANCE:

Insurance Company______________________________

Address______________________________

City____________________ State_______ Zip_______

Phone (   )______________________________

Group No.______________ Union/Local No.__________

Employee/Insured______________________________

Employee S.S. No. __ __ __ - __ __ - __ __ __ __

Employee Date of Birth ______/______/______

HEALTH (MEDICAL) INSURANCE:

Insurance Company______________________________

Address______________________________

City____________________ State_______ Zip_______

Phone (   )______________________________

Group No.______________ Union/Local No.__________

Employee/Insured______________________________

Employee S.S. No. __ __ __ - __ __ - __ __ __ __

Employee Date of Birth ______/______/______

Authorization, Understanding, Acceptance and Assignment

I (We), the undersigned, authorize the licensed dental professionals, clinical assistants, and support staff (you) of Delany Dental Care, Ltd. (DDC), to take x-rays, make study models, photographs, video displays and any other diagnostic aids you deem appropriate for the examination and diagnosis of the person named as patient on this form (patient), and to provide accepted treatment, medication and therapy which you find indicated. I understand that the use of anesthetic agents entails certain risks, and that exposure to certain dental supplies and materials, latex products in particular, may lead to adverse patient reaction.

I accept responsibility for payment of services provided to the patient. I agree to make full payment for those services at the time they are rendered unless alternative financial arrangements have been made and accepted by DDC. I authorize you to request and review credit and other information about me, and authorize any person or credit reporting agency to release to you any information they may have or obtain in response to your inquiries. I agree to pay DDC a finance charge at an *Annual Percentage Rate (APR)* of 18% (1.5% per month) on any balance which remains unpaid for more than 30 days, together with costs and reasonable attorney's fees which DDC incurs in collection. I assign to DDC all rights I have to insurance benefits for services rendered to me and I authorize my insurers to pay those benefits directly to DDC. I authorize DDC to release by mail, facsimile transmission or other electronic means any information about me related to those benefits.

Patient (X)______________________________ Date______________ Witness____________________

Parent/Resp. Party (X)______________________________ Date______________ Witness____________________