Time 11:06 AM

Jeremy B Matthews

Date 3/8/2018

NEW Medical History Form 2018

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Name of your currant physician ○ Yes ○ No If yes

Surgical Operations

Appendectomy ○ Yes ○ No	Back ○ Yes ○ No	Ear ○ Yes ○ No	Gallbladder ○ Yes ○ No
Heart ○ Yes ○ No	Hernia repair ○ Yes ○ No	Lung ○ Yes ○ No	Nasal ○ Yes ○ No
Thyroid ○ Yes ○ No	Tonsillectomy ○ Yes ○ No	Uvulectomy ○ Yes ○ No	Periodontal ○ Yes ○ No

Other: ○ Yes ○ No If yes

Family History

Has any member of your family (parent, sibling, or grandparent) had:

Cancer ○ Yes ○ No	Heart disease ○ Yes ○ No	Diabetes ○ Yes ○ No	High blood pressure ○ Yes ○ No
Stroke ○ Yes ○ No	Sleep disorder ○ Yes ○ No	Obesity ○ Yes ○ No	Thyroid disorder ○ Yes ○ No
Father snores ○ Yes ○ No	Mother snores ○ Yes ○ No	Father has sleep apnea ○ Yes ○ No	Mother has sleep apnea ○ Yes ○ No

Social History

Are you a tobacco user of one of the following:

Cigarettes ○ Yes ○ No	Pipe ○ Yes ○ No	Cigar ○ Yes ○ No	Snuff ○ Yes ○ No
Chew ○ Yes ○ No	Never used ○ Yes ○ No		

Currently smoking? How many packs a day? ○ Yes ○ No If yes

Quit smoking? When did you quit? ○ Yes ○ No If yes

Caffeine intake:

none ○ Yes ○ No	Coffee ○ Yes ○ No	Tea ○ Yes ○ No	Soda ○ Yes ○ No

Drink Caffeine? How much do you drink daily? ○ Yes ○ No If yes

Do you drink alcohol? # of drinks per week? ○ Yes ○ No If yes

Do you exercise? How often? ○ Yes ○ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Do you have any allergens to the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Antibiotics	☐ Sedatives	☐ Sleeping pills	☐ No known allergens

Other: ☐ If yes

Are you currently taking any medication? List: (NAME/DOSE/WHY?) ○ Yes ○ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Diabetes ○ Yes ○ No	Hepatitis ○ Yes ○ No	Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No
Renal Dialysis ○ Yes ○ No	Anemia ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No
Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No
High Cholesterol ○ Yes ○ No	Artificial Heart Valve ○ Yes ○ No	Artificial Joint ○ Yes ○ No	Hypoglycemia ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Sinus Trouble ○ Yes ○ No	Frequent Cough ○ Yes ○ No
Kidney Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No
Thyroid Disease ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No
Tonsillitis ○ Yes ○ No	Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No
Tuberculosis ○ Yes ○ No	Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No
Tumors or Growths ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Ulcers ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No
Psychiatric Care ○ Yes ○ No	Acid reflux ○ Yes ○ No	Atherosderosis ○ Yes ○ No	Bleed Easily ○ Yes ○ No
Chronic fatigue ○ Yes ○ No	Chronic Pain ○ Yes ○ No	COPD ○ Yes ○ No	Coronary heart disease ○ Yes ○ No
Depression ○ Yes ○ No	Difficulty sleeping ○ Yes ○ No	Daytime Sleepiness ○ Yes ○ No	Fibromyalgia ○ Yes ○ No
Immune system disorder ○ Yes ○ No	Insomnia ○ Yes ○ No	Ischemic heart disease ○ Yes ○ No	Mood Disorder ○ Yes ○ No
Multiple sclerosis ○ Yes ○ No	Nasal allergies ○ Yes ○ No	Neuralgia ○ Yes ○ No	Osteoarthritis ○ Yes ○ No
Parkinson's disease ○ Yes ○ No	Prior Orthodontics ○ Yes ○ No	Rheumatic arthritis ○ Yes ○ No	Sleep apnea ○ Yes ○ No

If you maked "YES" please list below: Current Status and Date of Diagnosis ○ Yes ○ No

Do you have any other Medical Condition not listed above? Please list below with Current status and Date of Diagnosis ○ Yes ○ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patent's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

DISHONORED FEE: Matthews Dental charges a $25 fee for any check or credit card that is dishonored for any reason.

PERMISSION TO CONTACT I grant my permission to Matthews Dental or assignee to telephone me at home, at my workplace, or on my cell phone to discuss matters related to this form. I agree to allow text messages with pertinent information to be texted to my personal cell phone number. I also agree to allow the office to leave voice mails concerning appoints and/or results. I also agree information may be left with a family member in the event I am not available, and someone else answers the number I have provided for this office to use to contact me.

48 HOUR CANCELLATION POLICY Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise. The office reserves the right to charge $50 per hour scheduled as a fee for any appointment that is missed/cancelled without giving the business 48 hours notice. This decision is at the discretion of the office.

SAFETY For the safety of yourself and our other patients no one is allowed in the operatory room throughout the course of your treatment. This includes both children and adults. We have a waiting room available for family members not being treated.

This agreement supersedes all prior signed agreements, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior agreements related to financial agreements or quality of care are null and void.

I acknowledge that I have received a copy of this office's PRIVACY POLICIES. I agree to disclose to the dentist the names of any individuals with whom I GIVE MY PERMISSION TO DISCUSS MY DENTAL CARE.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND. I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREIN.

_____ _____

Signature of Patient, parent or guardian Date

Please print name of patient _____