Plymouth Greene Dental

Dr. Elena Kachur

MEDICAL HISTORY FORM

Name: _____ _____ _____
First **Middle** **Last**

Address: _____ _____ _____ _____
Street address **City** **State** **Zip**

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Social Security #: _____

E-mail: _____

Date of Birth: _____ Age: _____ Sex: _____ Occupation: _____

Nearest Relative In Case of Emergency: _____ Phone: _____

MEDICAL QUESTIONNAIRE

For the following questions, please circle "Yes" or "No" as it applies to you. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical examination was on _____
4. Are you under the care of a physician? Yes No
   If yes, what is the condition your physician is treating? _____
5. The name and contact information of my physician(s) is:

Physician's Name: _____ Phone: _____

Physician Address: _____

_____ _____ _____
City **State** **Zip**

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If yes, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems:
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? ..... Yes No
   b. Cardiovascular disease: heart trouble, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke? ..... Yes No
9. Do you have or have you suffered from any of the following:
   a. Do you have inborn heart defects? ..... Yes No
   b. Do you have a cardiac pacemaker? ..... Yes No

Arthritis or Painful Swollen Joints	Yes	No	Problems with the Immune System	Yes	No
Asthma or Hay Fever	Yes	No	Problems with Mental Health	Yes	No
AIDS or HIV Infection	Yes	No	Persistent or blood producing cough	Yes	No
Cancer	Yes	No	Persistent Swollen Glands	Yes	No
Diabetes	Yes	No	Recent Weight Loss	Yes	No
Epilepsy or other neurological disease	Yes	No	Respiratory Problems	Yes	No
Fainting spells or seizures	Yes	No	Sinus Trouble	Yes	No
Hepatitis, Jaundice or Liver Disease	Yes	No	Stomach Ulcer or Hyperacidity	Yes	No
High or Low Blood Pressure	Yes	No	Thyroid Problems	Yes	No
Kidney Trouble	Yes	No	Tuberculosis	Yes	No

10.	Have you had abnormal bleedi...	Yes	No
	a. Have you ever required blood transfusion?	Yes	No
11.	Have you ever had any treatment for a tumor or growth?	Yes	No
12.	Are you **allergic** or have you had a reaction to:		
	a. Local anesthetics?	Yes	No
	b. Penicillin or other antibiotics?	Yes	No
	c. Sulfa Drugs?	Yes	No
	d. Barbiturates, sedatives, or sleeping pills?	Yes	No
	e. Aspirin?	Yes	No
	f. Iodine?	Yes	No
	g. Codeine or other narcotics?	Yes	No
	h. Other _____		
13.	Have you had any serious trouble associated with any previous dental treatment?	Yes	No
	If so, explain: _____		
14.	Do you have any disease, condition or problem not listed above that I should know about?	Yes	No

WOMEN

15.	Are you **pregnant**?	Yes	No
16.	Are you nursing?	Yes	No
17.	Are you taking birth control pills?	Yes	No
18.	Do you have any problems associated with your menstrual period?	Yes	No
	If so, explain: _____		

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient **Date**

Signature of Guardian/Parent (If patient is not 18 years old)

Signature of Treating Physician **Date**

INSURANCE INFORMATION

Dental Insurance Name: _____ **Phone:** _____

Subscriber : _____ **Social Security #:** _____

Group Number: _____ **Policy Number #:** _____

Limited Power of Attorney

This Dental Office is authorized to fill out and/or assist me in completing any and all insurance forms pertaining to services rendered. This Dental Office is also authorized to sign my name to insurance forms when payment is due them if I am not present to sign at that time.

Signature **Date**

Financial Responsibility

I hereby authorize and request the performance of dental services for myself or for _____ Age _____ I also give my consent to any advisable and necessary dental procedures, medications, and/or anesthetics to be administered by the attending physician or by the supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above-named, regardless of insurance coverage.

Signature of Responsible Party **Date**