HEALTH MEDICAL INFORMATION

Poor health ....yes no
Recent cold or cough ....yes no
Bleeding tendency..................................yes no
Hepatitis ....yes no
Heart trouble .... yes no
High blood pressure ....yes no
Liver disease ....yes no
Asthma ....yes no
Convulsions/seizures...............................yes no
Anemia ....yes no
Cancer ....yes no

Recent Illness...yes no
Chest pain ....yes no
Herpes ....yes no
Diabetes ....yes no
Pacemaker..yes no
Kidney disease ....yes no
Lung disease ....yes no
Rheumatic fever......................................yes no
HIV pos/AIDS ....yes no

If yes, are you currently being treated? ______

What kind of treatment?____

List ALL medications taken on a regular basis:

________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________

MUST you sleep with more than one pillow? .... Y N
Are you pregnant: .... Y N On birth control pills? Y N
Do you get short of breath easily? .... Y N
Have you been hospitalized within the last 5 years? .. Y N Why?________________________
Have you had any replacement surgery? .... Y N What kind?___________________

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/PAYMENT

Payment is due when services are provided.

I authorize the release of any information necessary to process my insurance claim(s). I authorize payment directly to my dentist and I agree to pay any balance not covered by my insurance company. I understand that all account balances after 30 days are subject to a finance charge of 1 ½ % per month; there is a $30.00 charge on all returned checks; and in the event no payment is made for three billing cycles, the account will be turned over to a collection agency with an additional collection fee of 30% of the unpaid balance. ***This office uses only composite material for fillings. In the event your insurance company does not cover the cost, you are responsible for any difference.***

Signature____ Date__________________________

Relationship to Patient____