Medical and Dental History

1. Are you currently under the care of a physician? □Yes □No Physician's Name: _____

Please list reasons: _____

2. Are you taking any prescription or over-the-counter drugs? □Yes □No

Please list each one: _____

3. Are you having any pain or discomfort at this time? □Yes □No If so, what? _____

4. Do you bleed excessively when you are injured? □Yes □No

5. *For Women:* Are you pregnant? □Yes □No * Are you nursing? □Yes □No * Are you taking Birth Control? □Yes □No

6. Are you taking or have you taken in the last two years any appetite suppressants, such as fen-phen? □Yes □No

Please list each one: _____

7. When you exercise do you ever have to stop because of pain in your chest, shortness of breath, or because you feel tired? □Yes □No

Please explain: _____

8. Do your ankles swell during the day? □Yes □No

9. Do you use more than two pillows to sleep? □Yes □No

10. Have you lost or gained more than ten pounds in the past year? □Yes □No

11. Do you ever wake up from sleep and feel short of breath? □Yes □No

12. Do you smoke or chew tobacco? □Yes □No If yes, how many packs a day? _____

13. Have you ever had any Periodontal (gum) treatment or Orthodontic corrections; for example Root Planning or Braces? □Yes □No

Please explain & give approximate date of completion: _____

14. Indicate which of the following you have had or have at the present time:

AIDS/HIV+	□Yes □No	Glaucoma	□Yes □No	Radiation/Chemotherapy	□Yes □No
Allergies/Sinus Trouble	□Yes □No	Heart Murmur	□Yes □No	Rheumatic Fever	□Yes □No
Arthritis	□Yes □No	Heart Problem	□Yes □No	Stroke	□Yes □No
Asthma	□Yes □No	Hepatitis A, B, or C	□Yes □No	Thyroid Problems	□Yes □No
Cancer	□Yes □No	High Blood Pressure	□Yes □No	Tuberculosis	□Yes □No
Diabetes	□Yes □No	Jaundice	□Yes □No	Venereal Disease	□Yes □No
Drug Addiction	□Yes □No	Kidney Trouble	□Yes □No	Other (explain below)	□Yes □No
Epilepsy/Seizures	□Yes □No	Mitral Valve Prolapse	□Yes □No		

If you checked Heart Problem or Other, please explain: _____

15. Indicate which of the following you may or may not be allergic to:

Acetaminophen	□Yes □No	Dental Anesthetics	□Yes □No	Latex Gloves	□Yes □No	Sulfa	□Yes □No
Aspirin	□Yes □No	Erythromycin	□Yes □No	Metals (Jewelry)	□Yes □No	Tetracycline	□Yes □No
Codeine	□Yes □No	Ibuprofen	□Yes □No	Penicillin	□Yes □No	Other	□Yes □No

Please list any other allergies you have: _____

16. Whom should we contact in case of an emergency? Name:_____ Phone: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

_____ * Date: _____
Signature Of Patient (Over 18 years of age)

_____ * Date: _____
Signature Of Parent Or Guardian (if patient is under 18 years of age)

MEDICAL HISTORY UPDATED

1. DATE:_____ REVIEWED BY DOCTOR:_____ 3. DATE:_____ REVIEWED BY DOCTOR:_____
2. DATE:_____ REVIEWED BY DOCTOR:_____ 4. DATE:_____ REVIEWED BY DOCTOR:_____

Consent for Services

The undersigned hereby authorizes Sacramento Dental Medicine to order x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by us to make a thorough diagnosis of the patients dental needs. I authorize Sacramento Dental Medicine to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I authorize and consent that Sacramento Dental Medicine choose and employ such assistance as deemed fit to provide recommended treatment.

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. Following diagnosis we will advise you of our treatment plan for you. After mutual agreement on your treatment plan, treatment will be rendered.

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 ail 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. Should the insurance company decide not to contribute or pay less than the **"guesstimate"**, you, the patient will be responsible for any difference owed. You will be presented various financial options and given an opportunity to select the plan that best suits your needs.

A service charge of $1^{1/2}$ % per month (18% per year) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. An additional fee of $25.00 per month will be added for all accounts not paid after 60 days.

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 Sacramento Dental Medicine, I agree to pay therefore the reasonable value of said services to Sacramento Dental Medicine, or his 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.
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in ,rny health and information on this form, I will inform the doctor at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

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

Relationship to Patient: _____

Rescheduling Notice

To be able to serve all patients with the same commitment, keep in mind that schedule appointments are extremely precious. <u>If you cannot keep a scheduled appointment, 2-business day's cancellation notice by you is required.</u> We do realize that certain emergencies are unavoidable and will take this into consideration.

Missed appointments without a 2-business day's notice will be charged at the rate of <u>$50 for each hour scheduled.</u> Please remember that other patients may have needed your scheduled time.

Patient Initials: _____