MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
Other If yes, please explain: _____

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
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problem Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease 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
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial ___ Sex: M F Birthdate _____ Age ___

Soc. Sec.# _____ If Patient is a Minor, give Parent's or Guardian's Name _____ Today's Date _____

Who may we thank for referring you to our office? _____ Reason for this visit? _____

Driver's License# _____ State _____ E-mail Address _____

If a Child, Parent's Name _____ Driver's License# _____

Mailing Address _____ City _____ State _____ Zip _____

Phone - Home: _____ Bus: _____ Cell: _____ Marital Status _____

Patient's Employer _____ Business Address _____

Present Position _____ How long held? _____

Spouse's Name _____ Spouses's SSN# _____

Spouse's Employer _____ Business Address _____ Bus Phone _____

Present Position _____ How long held? _____ Spouse's Date of Birth _____

INSURANCE INFORMATION

Who will pay this account? _____ Do you have insurance? YES or NO (circle one)

Name of Insurance _____ Group No. _____

Who is the Subscriber? _____ Subscriber's Birthdate _____

Subscriber's SSN# _____ Employer _____

Circle Method of Payment: Cash Check Credit Card Care Credit

My signature authorizes release of my medical information and x-rays; and authorizes payment directly to Max S. Breazeal, D.D.S. upon completion of treatment.

Signature of Responsible Party _____ Date _____ Relationship to Patient _____

OFFICE POLICY

INSURANCE

I UNDERSTAND THAT DR. BREAZEAL IS AN OUT OF NETWORK PROVIDER AND THAT I AM RESPONSIBLE FOR MY INSURANCE DEDUCTIBLE AND CO-PAYS, SET OUT BY MY INSURANCE COMPANY, ON THE DAY SERVICES ARE RENDERED. I also understand that my dental insurance is a contract between me and the insurance company not between the insurance company and Dr. Breazeal. ***I UNDERSTAND THAT AS A COURTESY TO ME, DR. BREAZEAL'S OFFICE WILL FILE MY INSURANCE, HOWEVER I AM STILL RESPONSIBLE FOR ALL DENTAL CHARGES.*** If the insurance company has not paid their portion within the 30 days of being properly billed, as mandated by the insurance Commissioner of the State of Tennessee, I understand that the balance will become due and payable from me.

DELINQUENT ACCOUNTS

I understand that payment is due at the time services are rendered unless payment arrangements have been made and approved in advance. All unpaid balances will be subject to a finance charge after 90 days of 1.5 % per month, which is an annual percentage rate of 18%. In the event we are forced to submit a delinquent account to a collection agency, I am responsible for any legal interest on the balance due together with any collection agency costs and attorney's fees incurred to collect on this account.

FAILED APPOINTMENT CHARGE

I understand that as a courtesy to me, I will be mailed a reminder card 2-3 weeks prior to appointment and followed up with a call the day before the appointment to confirm. ***IF I FAIL MY APPOINTMENT, A $25 MISSED APPOINTMENT CHARGE WILL BE ADDED TO MY ACCOUNT.*** If appointments cannot be kept, please call within 24 hours of appointment time to cancel or reschedule. Otherwise, you will be charged for a failed appointment.

RETURNED CHECKS

All returned checks are subject to a $50 service fee. Any returned checks must be resolved before any future appointments can be arranged.

I understand that responsibility for payment for dental servies provided for my dependent or myself is MINE, due and payable at the time services are renered.

PATIENT Signature _____ Date _____ Relationship to Patient _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

MEDICAL HISTORY

	YES	NO	
Are you under a PHYSICIAN'S CARE now?	❑	❑	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	❑	❑	If yes, please explain: _____
Have you ever had a serious head or neck injury?	❑	❑	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	❑	❑	If yes, please explain: _____
Do you use tobacco?	❑	❑	
DO YOU TAKE, OR HAVE YOU TAKEN FOSMAX, ACTONE, BONIVIA OR EVISTA FOR OSTEOPOROSIS?	❑	❑	

WOMEN
❑ PREGNANT/Trying to get pregnant? ❑ Nursing
❑ Taking oral contraceptives?

Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Nitrous Oxide
❑ Other If Yes Please Explain: _____

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

❑ AIDS/HIV Positive	❑ Chest Pains	❑ Frequent Headaches	❑ Hypoglycemia	❑ Rheumatic Fever
❑ Alzheimer's Disease	❑ Cold Sores/Fever Blisters	❑ Genital Herpes	❑ Irregular Heartbeat	❑ Scarlet Fever
❑ Anaphylaxis	❑ Congenital Heart Disorder	❑ Glaucoma	❑ Kidney Problems	❑ Shingles
❑ Anemia	❑ Convulsions	❑ Hay Fever	❑ Leukemia	❑ Sickle Cell Disease
❑ Angina	❑ Cortisone Medicine	❑ Heart Attack/Failure	❑ Liver disease	❑ Sinus Trouble
❑ Arthritis/Gout	❑ Diabetes	❑ Heart Murmur	❑ Low blood Pressure	❑ Spina Bifida
❑ Artificial Heart Valve	❑ Drug Addiction	❑ Heart Pace Maker	❑ Lung Disease	❑ Stomach/Intestinal Disease
❑ Artificial Joint	❑ Easily Winded	❑ Heart Trouble/Disease	❑ Mitral Valve Prolapse	❑ Stroke
❑ Asthma	❑ Emphysema	❑ Hemophilia	❑ Osteoporosis	❑ Swelling of limbs
❑ Blood Disease	❑ Epilepsy or Seizures	❑ Hepatitis A	❑ Pain in Jaw Joints	❑ Thyroid Disease
❑ Blood Transfusion	❑ Excessive Bleeding	❑ Hepatitis B or C	❑ Parathyroid Disease	❑ Tonsillitis
❑ Breathing Problem	❑ Excessive Thirst	❑ Herpes	❑ Psychiatric Care	❑ Tuberculosis
❑ Bruise Easily	❑ Fainting Spells/Dizziness	❑ High Blood Pressure	❑ Radiation Treatment	❑ Tumors or Growths
❑ Cancer	❑ Frequent Cough	❑ High Cholesterol	❑ Recent Weight Loss	❑ Ulcers
❑ Chemotherapy	❑ Frequent Diarrhea	❑ Hives or Rash	❑ Renal Dialysis	❑ Venereal Disease
				❑ Yellow Jaundice

DENTAL HISTORY

HOW LONG SINCE you have seen a dentist? _____
Last FULL MOUTH X-RAYS,
(16 Small Films or Panoramic) Date _____

	YES	NO
Are you having PROBLEMS now?	❑	❑
If so, what? _____		
Are your teeth sensitive to hot, cold, sweets, pressure? (Circle)	❑	❑
Do you wear dentures or partials?	❑	❑
Would you like to know more about PERMANENT REPLACEMENTS?	❑	❑
Are you APPREHENSIVE about dental treatment?	❑	❑
Have you had any PERIODONTAL (GUM) treatments?	❑	❑
Do your gums BLEED, or feel TENDER or IRRITATED?	❑	❑
Are you aware of GRINDING or CLENCHING your teeth?	❑	❑
Do you have HEADACHES, EARACHES, or NECK PAIN?	❑	❑
How do you feel about your teeth? Satisfied or Need Improvement(Circle One)		
Do you have discolored teeth that bother you?	❑	❑
Are you unhappy with the appearance of your teeth?	❑	❑
Would you like your smile to look better or different?	❑	❑
Are you interested in whitening your teeth?	❑	❑

LIST ALL MEDICATIONS TAKEN DAILY

(Prescribed and Over the Counter)

_____
_____
_____
_____
_____

Is there any other Medical or Dental information that you feel I should know about? _____

_____

FAMILY PHYSICIAN _____

PHYSICIAN PHONE NO. _____

Have you ever had any serious illness not listed above? ❑ YES ❑ NO

If yes, please explain: _____

_____
_____
_____

Patient Signature _____ Date: _____