MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y N
Anaphylaxis	Y N
Latex	Y N
Local Anesthetics	Y N
Penicillin	Y N
Metal	Y N
Sulpha	Y N
Other	Y N

List other known allergies

_____

_____

_____

_____

Cardiovascular

Artificial Heart Valve	Y N
Coronary Artery Disease	Y N
Chest Pain or Angina	Y N
Congestive Heart Failure	Y N
Heart Attack	Y N
Heart Murmur	Y N
High Blood Pressure	Y N
High Cholesterol	Y N
Irregular Heart Beat	Y N
Low Blood Pressure	Y N
Mitral Valve Prolapse	Y N
Pacemaker	Y N
Tachycardia	Y N

Endocrine

Diabetes	Y N
Gout	Y N
Hormonal Change	Y N
Thyroid Problems	Y N

Eyes, Ears, Nose, and Throat

Change in Hearing	Y N
Change in Vision	Y N
Dysphagia	Y N
Ear Pain	Y N
Glaucoma	Y N
Hay Fever	Y N
Nasal Obstruction	Y N
Nose Bleeding	Y N
Sinus Problems	Y N
Tonsillectomy	Y N
Tinnitus (Ringing)	Y N

Gastrointestinal

Acid Reflux	Y N
GERD	Y N
Soft or Special Diet	Y N
Ulcers	Y N

Genitourinary

Frequent Urination	Y N
Kidney Disease	Y N

General

Current Weight_____

Height_____ft_____ in

Cancer	Y N
Fatigue/Tired	Y N
General Weakness	Y N
Headaches	Y N
HIV/AIDS	Y N
Knee/hip Replacement	Y N
Liver Problems	Y N
Recent Trauma or Injury	Y N
Rheumatic Fever	Y N
Radiation Treatment	Y N
Weight Change	Y N

Hematological

Bleeding Problems	Y N
Hepatitis	Y N

Oral

Bleeding gums	Y N
Dry Mouth	Y N
Jaw Problems(TMJ)?	Y N
Clicking?	Y N
Pain?	Y N
Difficulty swallowing?	Y N
Difficulty chewing?	Y N
Orthodontics/Invisalign	Y N
Periodontal Disease	Y N
Teeth clenching	Y N
Teeth grinding	Y N
Tooth Pain	Y N
Wisdom teeth extraction	Y N

Do you wear removable teeth? Y N

Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal

Back Pain	Y N
Fibromyalgia	Y N
Joint Pain	Y N

Neurological

Alzheimer's Disease	Y N
Dizziness	Y N
Fainting	Y N
Memory Loss	Y N
Multiple Sclerosis	Y N
Muscle Weakness	Y N
Seizures	Y N
Stroke	Y N
Tingling/Numbness	Y N
Trigeminal Neuralgia	Y N
Tremor	Y N

Psychiatric

ADD/ADHD	Y N
Anxiety	Y N
Chemical Dependency	Y N
Depression	Y N
Eating Disorder	Y N
Excessive Stress	Y N
Memory Problems	Y N

Respiratory

Asthma	Y N
Bronchitis	Y N
Breathing Problems	Y N
Chest Pressure	Y N
Congestion	Y N
Dyspnea (shortness of breath)	Y N
Emphysema	Y N
Orthopnea	Y N
Pneumonia	Y N
Pulmonary Embolism	Y N
Tuberculosis	Y N

Sleep

Daytime Sleepiness	Y N
Morning Headache	Y N
Obstructive Sleep Apnea	Y N
Do you us a CPAP?	Y N

How often?_____

Has anyone told you that you snore? Y N

Social History

Do you smoke? Y N___packs a day?

Do you use smokeless tobacco Y N

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? Y N

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Skyline Family Dentistry

Gabriel Overholtzer D.D.S

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medications	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalizations you have had:

Date (year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

_____

_____

_____

Primary Physician's Name: _____Physician's phone#_____

Are you under the care of another physician's If so, please list:

Physician Phone# Reason

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Gabriel Overholtzer DDS to take radiographs, study model, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Gabriel Overholtzer DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Gabriel Overholtzer DDS choose and employ such assistance as appropriate by Gabriel Overholtzer DDS. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees necessary to services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 ½% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Gabriel Overholtzer DDS and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claims appeal(s) on my behalf

Consent (adult)

Name of Patient_____ _____ **Date**_____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian_____ _____ **Date**_____

Signature of Patent/Guardian

NOTICE OF PRIVACY PRACTICES (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") And to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below, you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers

Signature of Patient_____ **Date** _____

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Gabriel Overholtzer DDS

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