Health History

O Have you been hospitalized in the past 5 Years? If yes, reason_____
_____

O Are you currently receiving care?
If yes, nature of care:_____
_____

Date of last health care exam: _____
What was this exam for?_____
_____
What is the name of your current physician?
_____

For the following questions, **please check all that apply**. Your answers are for our records only and will be confidential. Please note that during your visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

O Acid Reflux
O Allergies
O Arthritis
O Blood Disease
O Cancer
O Cervical Pain
O Clenching / Bruxing
O Clicking / Popping (TMJ)
O Dental Anxiety
O Diabetes
O Difficulty Chewing
O Emphysema
O Epilepsy
O Excessive Bleeding
O Facial Pain
O Glaucoma
O Headaches
O Head Injuries
O Hepatitis, any form
O High Blood Pressure
O HIV Positive or AIDS
O Hypoglycemia
O Insomnia
O Joint Replacement
O Kidney Disease
O Liver Disease
O Limited Opening
O Migraine Headaches
O Mitral Valve Prolapse
O Nervous Disorders
O Organ Transplant
O Osteoporosis
O Pacemaker
O Pressure Behind Eyes
O Radiation Treatment
O Rheumatic Fever
O Sinus Problems
O Stroke
O Thyroid
O Tinnitus
O TMJ Pain
O Ulcers
O Vertigo (Dizziness)

Women:
O Are you pregnant?
O If no, are you planning a pregnancy in the near future?
O Currently a nursing mother?
O Currently taking Birth Control?
O Have you ever had Botox?

Allergies

Are you allergic or have you had a reaction to:

O Local Anesthetic
O Latex Allergy
O Codeine
O Erythromycin
O Sulfa
O Other _____
O Penicillin or other antibiotics
O Aspirin

Please list any medications you are currently taking:

_____
_____

Authorization, Release, Photography Release & Agreement to pay for services rendered

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. ***Payment is due in full at the time of treatment,*** *unless prior arrangements have been made. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. The team at Dr. Ramirez' office often takes digital photos in order to properly document the condition of your teeth and gums. Additionally, these photos will help us to make more accurate diagnosis. Dr. Ramirez may publish articles and make presentations to other dentists where these photos are invaluable in explaining the latest techniques and the results that can be achieved. Signing this document acknowledges that photographs of me may be used for educational purposes as stated above.*

Signature_____ *Date*_____