



# Medical History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary care physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under physician's care for any thing specific(please explain): \_\_\_\_\_

When was your last complete physical exam: \_\_\_\_\_

Please list any medication you are taking including vitamins or suppliments: \_\_\_\_\_

Do you have any allergies(medications, latex, metal sensitivities)	Y / N
please list if so:	
Are you pregnant or do you suspect you may be?	Y / N
Do you use birth control?	Y / N
Have you ever been treated for or do you have heart disease?	Y / N
Do you have a pacemaker, artificial heart valve implant, or been diagnosed with mitral valve prolapse?	Y / N
Have you ever had rheumatic fever?	Y / N
Are you aware of any heart murmurs?	Y / N
Do you have high or low blood pressure?(please circle)	H/L / N
Have you ever had a serious illness or major surgery?	Y / N
If so please explain:	
Have you ever had radiation treatment,chemo treatment for tumor,growth or condition?	Y / N
Have you ever taken Fosamax,Zometa,Aredia, or any other oral intravenous treatment (biophosphonates) for bone tumors, excessive calcium in you blood, or osteoporosis?	Y / N
Do you have inflammatory diseases, such as arthritis or rheumatism?	Y / N
Do you have any artificial joints/prosthesis?	Y / N
Do you have any blood disorders, such as anemia, leukemia, or have you ever bled excessively after being cut or injured?	Y / N
Do you have any stomach problems?	Y / N
Do you have any kidney or liver problems?(please circle)	Y / N
Are you Diabetic?	Y / N
Do you have fainting or dizzy spells?	Y / N
Do you have asthma?	Y / N
Do you have epilepsy or seizure disorders?	Y / N
Do you have or have you had venereal or an sexually transmitted disease?	Y / N
Do you have AIDS or have you tested positive for HIV?	Y / N
Do you have or do you test positive for hepatitis?	Y / N
Do you have or have you had T.B.?	Y / N
Do you smoke, chew, use snuff or any other forms of tobacco?	Y / N
Do you regularly consume more than one or two alcoholic beverages a day?	Y / N
Do you habitually use controlled substances?	Y / N
Have you had psychiatric treatment?	Y / N
Have you taken any prescription drugs fenfluramine, fenfluramine combined with pentermine(fen-phen), dexfenfluramine(redux), or other weight loss products?	Y / N
Do you have any disease or condition not listed? If so, explain	Y / N
Would you like to speak to the doctor privately about any problem?	Y / N

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Dental History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the main reason for your appointment today:

\_\_\_\_\_

Please list any significant dental history:

How important is the way your teeth look?	Low	Medium	High
please list any specific concerns:			
How well can you chew?	Poor	Fair	Well
please list any specific concerns:			
Have you ever been diagnosed with a problem with either jaw or joint?			Y / N
Do you wear a night guard?			Y / N
Does your jaw click, pop, or make noise when you open or close?			Y / N
Do you have pain or tenderness in your jaw when you open, close or chew?			Y / N
Has your jaw ever locked open or closed?			Y / N
Do you have frequent head aches? If so how often or when?			Y / N
Do you clench or grind your teeth, or been told that you do?			Y / N
Do you have history of trauma to your chin or jaw?			Y / N
Do you or have you been told that you snore			Y / N
Have you been diagnosed with sleep apnea?			Y / N
Do you wear a CPAP or dental appliance?			Y / N
Please list any any additional concerns/details below:			

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Corey G. Warrenbrand, DMD

## Notice of Privacy Practices for Protected Health Information

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!**

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

**Cancellation Policy** - We request that you please call at least 48 hours prior to your scheduled appointment so that we may give that appointment time to another patient with dental needs. We reserve the right to charge a cancellation fee or require prepayment before rescheduling for repeat cancellations.

**Financial Policy** - Dental treatment is an excellent value and investment in an individual's medical and psychological well-being. We accept and file dental insurance on your behalf. Insurance estimates are never a guaranteed amount. We calculate insurance estimates based on the information provided to us by your insurance company. Your portion of the estimate will be due at time of service. Any balance after insurance payment is received will be your responsibility. We accept the following payment options:

- Cash or Personal Check
- Credit Card
- Monthly Payments
- (Available for balance over \$500, please inquire with Treatment Coordinator)

\_\_\_\_\_ Date: \_\_\_\_\_

**Patient Signature**