MEDICAL HISTORY

It is not our responsibility to determine if you require Pre-Med before your appointment; due to pre-existing medical conditions (knee replacement, Mitral valve prolapse, etc.) We can call in a prescription of antibiotics if your primary physician requires.

1. Do you have a current MEDICAL problem? . . . . . [ ] YES [ ] NO
   If yes, please explain: _____
2. Have you had a serious illness or hospitalization within the past 5 years? . . . . . [ ] YES [ ] NO

3a. WOMEN: Are you pregnant? If yes, due date: _____ . . . . . [ ] YES [ ] NO

3b. Do you take birth control? . . . . . [ ] YES [ ] NO
   Doctor – verbal warning given (re: antibiotics) _____

4. Do you have any of the following conditions? **(PLEASE CIRCLE)**

High Blood Pressure	Congenital Heart Problems	Stroke (year = _____)
Angina (chest pain)	Mitral Valve Prolapse	Heart Murmur
Heart Attack (year = ____)	Rheumatic Fever (year = ___)	
Heart Surgery (year = ____)	Heart Valve Damage or Replacement	

   Other : _____

5. Have you ever had a hip or other joint replacement? . . . . . [ ] YES [ ] NO
   Year: _____ Type of Joint: _____
6. Have you been advised to take an antibiotic before EVERY dental treatment? . . . . . [ ] YES [ ] NO

7. Please check if you now have, or have you ever had any of the following conditions:
   - Diabetes (circle: Insulin or Oral Medications) . . . . . [ ] YES [ ] NO
   - Kidney Problems . . . . . [ ] YES [ ] NO
   - Excessive Bleeding . . . . . [ ] YES [ ] NO
   - Stomach or Intestinal Ulcers . . . . . [ ] YES [ ] NO
   - Tuberculosis (year: _____) . . . . . [ ] YES [ ] NO
   - Asthma, Emphysema or Breathing Problems (please circle) . . . . . [ ] YES [ ] NO
   - Fainting Spells, Convulsions or Epilepsy (please circle) . . . . . [ ] YES [ ] NO
   - Glaucoma (pressure in the eyes) . . . . . [ ] YES [ ] NO
   - Blood Disease: Anemia, Leukemia, AIDS or HIV, Venereal Disease (please circle) . . . . . [ ] YES [ ] NO
   - Liver Disease/ Jaundice (year: _____) . . . . . [ ] YES [ ] NO
   - Hepatitis: (Please circle type) . . . . . [ ] YES [ ] NO
     Type A Infectious (Food), Type B Serum (Blood), Type C (Blood), Unknown Type . . [ ]YES [ ] NO

8. Are you allergic to , or have had an unusual reaction to: (Please circle)

Penicillin/Amoxicillin	Clindamycin	Erythromycin	Keflex	Aspirin	Codeine
Epinephrine/ Adrenaline	Nitrous Oxide	Lidocaine (Xylocaine)		Latex	Sulfa

   Other:

_____

9. Are you currently taking or have previously taken bisphosphonate medications, such as Actonel, Fosamax, or Zometa within the last 12 months? . . . . . [ ] YES [ ] NO

10.Please list ALL MEDICATIONS & DOSAGE which you are currently taking, including herbal supplements and those that you have been advised to take by a dentist/physician :

_____
_____
_____
_____

11. Do you smoke? (Please circle: Tobacco – Marijuana) . . . . . [ ] YES [ ] NO

Do you use "Recreational Drugs" (ex: Cocaine, Stimulants, Depressants, etc ..) . . . . . [ ] YES [ ] NO
These drugs may have serious interactions with anesthetics. This information is held strictly confidential .

Patient's Signature: _____ **Date:** _____

LARRY E.TRAGESSER, D.D.S

I prefer to be called: _____

Name_____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home #: _____

Work #: _____ Ext: _____

Cell #: _____

Email: _____

Phone:_____

Birthdate: _____

Social Security #: _____

Driver's License #: _____

Employer: _____

Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Name: _____

Phone #: _____ Relationship: _____

Spouse Information

Name_____

Birthdate: _____

Social Security #: _____

Employer: _____

Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Ext: _____

Cell #: _____

Insurance claim submission is offered as courtesy. Regardless of insurance coverage, the balance on account is your responsibility. If you would like our office to submit your insurance claim on your behalf, please complete the following:

Policyholder's Name: _____

Social Security#: _____

Birthdate: _____Group #: _____

Insurance Carrier: _____

Address: _____

City: _____ State: ____ Zip: _____

Secondary Insurance Information

Policyholder's Name: _____

Social Security #: _____

Birthdate: _____Group #: _____

Insurance Carrier: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Informed Consent

All the information on this form are true and correct to the best of my knowledge. I authorize the taking of radio graphs, photographs or other diagnostic measures appreciate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist in this office and the office staff as needed.

The information I have provided above is true and correct to the best of my knowledge.

Patient's signature: _____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/ USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPPA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgment form, If terms of our Notice change, a vised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of patient or Legal Representative Date

_____ _____

Printed Name of Patient Legal Relationship to the Patient

Consent to email or text for the appointment reminds and other healthcare communication.

If you approve, we may contact you via email and /or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke the consent at any time,

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please Initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please Initial _____.

OR

_____ I decline to receive communications via text.

_____ I decline to receive communications via email.