

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST EXAM _____

PATIENT'S NAME _____

BIRTHDATE _____ AGE _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? Indicate With a Check Mark ()

- | | |
|--------------------------------|---------------------------|
| _____ HEART MURMUR | _____ DIABETES |
| _____ ANY HEART PROBLEMS | _____ EPILEPSY / SEIZURES |
| _____ MITRO VALVE PROLAPSE | _____ HEPATITIS |
| _____ BLOOD PRESSURE | _____ HERPES |
| _____ CIRCULATORY PROBLEMS | _____ CANCER |
| _____ NERVOUS PROBLEMS | _____ MEASLES |
| _____ RADIATION TREATMENTS | _____ ASTHMA |
| _____ EXCESSIVE BLEEDING | _____ PSYCHIATRIC CARE |
| _____ AIDS | _____ RHEUMATIC FEVER |
| _____ HIV | _____ SCARLET FEVER |
| _____ HISTORY OF FAINTING | _____ SINUS PROBLEMS |
| _____ ALLERGIES TO ANESTHETICS | _____ STROKE |
| _____ ALLERGIES TO MED / DRUGS | _____ TUBERCULOSIS |
| _____ ANEMIA | _____ ULCER |
| _____ ARTHRITIS | _____ VENEREAL DISEASE |

CURRENT MEDICATIONS

PLEASE LIST ANY CURRENT MEDICAL TREATMENT OR MEDICATIONS:

HOW DID YOU HEAR ABOUT OUR OFFICE? Check One ()

YELLOW PAGES _____ INSURANCE _____ OTHER _____ FRIEND OR RELATIVE _____

NAME OF FRIEND OR RELATIVE _____

• PAYMENT IS DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE WILL FILE YOUR INSURANCE. HOWEVER, DEDUCTIBLE AND CO-INSURANCE ARE DUE AT THE TIME OF TREATMENT. IF YOUR INSURANCE DOES NOT PAY YOUR CLAIM WITHIN 60 DAYS, YOU WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT DUE. FINANCE CHARGES AT THE RATE OF 1.5% PER MONTH ACCRUE ON THE BALANCE.

DATE _____ SIGNATURE _____

(PATIENT OR GUARDIAN OF A MINOR)