DR. GEORGE SALEM and ASSOCIATES, PC

Excellence in Dentistry

PATIENT MEDICAL HISTORY

Patient's Name (please print) _____

How did you hear of our practice? _____

If a patient referred you here, who may we thank for referring you? _____

MEDICAL HEALTH

How is your general health? Excellent ❑ Good ❑ Fair ❑ Poor ❑

Who is your physician? Dr. _____ Address _____ Tel. _____

Do you have now or have you ever had any major medical problems? Yes ❑ No ❑

Have you ever been hospitalized? Yes ❑ No ❑

If yes, for what: _____

Are you now, or have you recently been taking any drug or medication? Yes ❑ No ❑

If yes, please list all medications and dosages.

1. Medication _____ Dosage _____ 3. Medication _____ Dosage _____

2. Medication _____ Dosage _____ 4. Medication _____ Dosage _____

Are you allergic or sensitive to any drugs or medicine (e.g. penicillin, aspirin, etc.)? Yes ❑ No ❑

If yes, please list _____

_____

Are you allergic to latex? Yes ❑ No ❑

Do you have any difficulty with bleeding or healing from a cut, wound, or extraction? Yes ❑ No ❑

Were you ever premedicated with antibiotics for dental work? Yes ❑ No ❑

Do you smoke? Yes ❑ No ❑ If yes, how much and how long? _____

Do you have or have you ever had any of the following problems?

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	❑	❑	Allergies	❑	❑	Liver Disease	❑	❑
Heart Murmur	❑	❑	Nervous Disorder	❑	❑	Thyroid Disease	❑	❑
Heart Disease	❑	❑	Fainting Spells	❑	❑	Sinus Problems	❑	❑
Angina or Chest Pain	❑	❑	Diabetes	❑	❑	Skin Disease	❑	❑
High Blood Pressure	❑	❑	Arthritis	❑	❑	Venereal Disease	❑	❑
Stroke	❑	❑	Cancer	❑	❑	Herpes	❑	❑
Anemia or Blood Disease	❑	❑	Tumors or Growths	❑	❑	A.I.D.S.	❑	❑
Lung Disease	❑	❑	Kidney Disease	❑	❑	Hepatitis	❑	❑
Asthma	❑	❑	Seizure Disorders (epilepsy)	❑	❑	Glaucoma	❑	❑
Hay Fever	❑	❑	Stomach/Intestinal (ulcers)	❑	❑	Women: Are you pregnant?	❑	❑

■ If yes to any of the above, please explain _____

_____

■ When was your last physical exam? _____

SIGNATURE (Patient/Guardian) _____ Date _____

Doctor's Note _____

SIGNATURE (Doctor) _____ Date _____

❑ No known allergies

PATIENT INFORMATION

■ PATIENT NAME (PLEASE PRINT)	SEX M	SEX F	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	MARITAL STATUS S	M	W	D	SEP

STREET ADDRESS ❑ PERMANENT ❑ TEMPORARY	CITY, STATE, ZIP		■ HOME PHONE NUMBER
■ PATIENTS EMPLOYER (IF STUDENT, NAME OF SCHOOL)	OCCUPATION ❑ FULL-TIME ❑ PART-TIME	HOW LONG EMPLOYED/ YEAR AT SCHOOL	■ BUSINESS PHONE NO. EXT.
■ EMAIL ADDRESS	EMPLOYER ADDRESS		■ CELL PHONE
■ SPOUSE NAME	SPOUSE'S SOCIAL SECURITY NO.	NUMBER OF CHILDREN AND AGES	
■ SPOUSE'S EMPLOYER	OCCUPATION ❑ FULL-TIME ❑ PART-TIME	HOW LONG EMPLOYED/ YEAR AT SCHOOL	■ BUSINESS PHONE NO. EXT.
EMPLOYERS STREET ADDRESS	CITY, STATE, ZIP		■ CELL PHONE
CLOSE RELATIVE IN CASE OF EMERGENCY	RELATIONSHIP / RELATIVES STREET ADDRESS		■ HOME PHONE NUMBER
EMPLOYER	EMPLOYERS ADDRESS		■ BUSINESS PHONE NO. EXT.

IF THE PATIENT IS A MINOR OR STUDENT

MOTHERS NAME	STREET ADDRESS, CITY, STATE, ZIP		HOME PHONE NUMBER
MOTHERS EMPLOYER	OCCUPATION ❑ FULL-TIME ❑ PART-TIME	HOW LONG EMPLOYED?	BUSINESS PHONE NO. EXT.
EMPLOYERS STREET ADDRESS	CITY, STATE, ZIP		CELL PHONE
FATHERS NAME	STREET ADDRESS, CITY, STATE, ZIP		HOME PHONE NUMBER
FATHERS EMPLOYER	OCCUPATION ❑ FULL-TIME ❑ PART-TIME	HOW LONG EMPLOYED?	BUSINESS PHONE NO. EXT.
EMPLOYERS STREET ADDRESS	CITY, STATE, ZIP		CELL PHONE

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY TREATMENT PERFORMED, WHETHER OR NOT I HAVE DENTAL INSURANCE COVERAGE, FURTHERMORE, I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE ABOVE NAMED DENTIST OTHERWISE PAYABLE TO ME.

PLEASE SIGN _____ _____

SIGNATURE (PATIENT/GUARDIAN) DATE

INSURANCE INFORMATION: ***IF YOU WISH US TO PROCESS INSURANCE CLAIMS, THIS PORTION MUST BE COMPLETED.***

1ST OR PRIMARY INSURANCE CARRIER	2ND OR PRIMARY INSURANCE CARRIER	MEDICAL INSURANCE CARRIER
EMPLOYERS NAME	EMPLOYERS NAME	EMPLOYERS NAME
EMPLOYERS ADDRESS	EMPLOYERS ADDRESS	EMPLOYERS ADDRESS
SUBSCRIBER DOB		
EMPLOYEES/SUBSCRIBER NAME	EMPLOYEES/SUBSCRIBER NAME	EMPLOYEES/SUBSCRIBER NAME
EMPLOYEES/SUBSCRIBERS SOCIAL SECURITY NUMBER	EMPLOYEES/SUBSCRIBERS SOCIAL SECURITY NUMBER	EMPLOYEES/SUBSCRIBERS SOCIAL SECURITY NUMBER
PATIENTS RELATIONSHIP TO EMPLOYEE/SUBSCRIBER SELF SPOUSE CHILD OTHER	PATIENTS RELATIONSHIP TO EMPLOYEE/SUBSCRIBER SELF SPOUSE CHILD OTHER	PATIENTS RELATIONSHIP TO EMPLOYEE/SUBSCRIBER SELF SPOUSE CHILD OTHER
INS. COMPANY	INS. COMPANY	INS. COMPANY
NAME	NAME	NAME
ADDRESS	ADDRESS	ADDRESS
GROUP PLAN NAME _____ GROUP PLAN _____	GROUP PLAN NAME _____ GROUP PLAN _____	GROUP PLAN NAME _____ GROUP PLAN _____
DEDUCTIBLES YES NO $ _____	DEDUCTIBLES YES NO $ _____	DEDUCTIBLES YES NO $ _____
MAXIMUM BENEFIT PER YEAR $ _____	MAXIMUM BENEFIT PER YEAR $ _____	MAXIMUM BENEFIT PER YEAR $ _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.

_____ _____ _____ _____

SIGNATURE (PATIENT/GUARDIAN) DATE SIGNED (INSURED PERSON) DATE

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED.

THE INVESTMENT NECESSARY TO COMPLETE DENTAL TREATMENT IS AN ESTIMATE BASED ON INFORMATION FROM OUR EXAMINATION. SHOULD ADDITIONAL PROBLEMS ARISE AS TREATMENT PROGRESSES, THIS ESTIMATE MAY ME REVISED. THIS WILL BE HONORED FOR A PERIOD OF THREE (3) MONTHS ONLY.