MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Franklinville Family & Cosmetic Dentistry
Disclaimer

Payment is expected at time of service. If you have dental benefits, your co-payment and deductible are due at time of service.

- Your insurance is **NOT** a guarantee of payment. We bill your insurance as a courtesy for you so you do not have to submit your own claims. However, if there is a difference after we receive word from your insurance, it then becomes **YOUR** balance.

- If you have insurance, it is your responsibility to calculate your maximum benefits annually either per calendar year or benefit year. We do the best we can to keep track, however it is **YOUR** responsibility to know what you have remaining.

- We **estimate** your co-pays!!! If you need special arrangements, we need to know before your appointment-not during so we can offer you financial plans. While we help you to maximize your allowance insurance benefit, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us. Any unpaid balances by your insurance remains your responsibility, including the balance exceeding usual and customary rates (UCR).

- We have the right to charge anyone who is late paying on their account a fee of $10 for each month missed.

- We need 24 to 48 hours notice to cancel any appointments. Our time is just as valuable as yours. If you cancel your appointment the same day you are scheduled, we have the right to charge you up to one dollar per minute you booked of the physician's time. We do understand that emergencies arise and will reschedule your appointment. We also have the right to dismiss a patient if they have repeatedly missed or canceled appointments.

- **SECONDARY INSURANCE**: Having more than one insurance DOES NOT necessarily mean that your services are covered at 100%. As a courtesy we will gladly bill your secondary insurance. Any balance not paid by your secondary insurance company remains your responsibility.

- **Divorce Decrees**: This office is **NOT** a party of your divorce decree. Adults are responsible for their bill during time of service. If you accompany a minor, the adult who is here with the child is responsible for the bill. We can not send a bill to another party. Payment is due during time of service.

- If you let your insurance dictate what dental treatment you need to improve your smile and the health of your teeth & gums, please let us know so we can refer you out. **WE WON'T TREAT YOU THAT BAD ☺**

Patient Signature:_____

Guardian/Patient Signature:_____**Date:**_____

Todd M Gottlieb. D.M.D
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Franklinville, NJ 08322

NOTICE OF PRIVACY PRACTICES

The notices given prior to this form explain how we are handling YOUR privacy as our patient in this office. You are entitled to designate with whom we can or can not discuss your treatment and/or financial information with. With this law, you are entitled to FULL privacy of your account. Please list and date the people we can discuss your account with. For example, if your spouse takes care of finances and calls in regards to a statement he or she has received, the patient must list this person on this form in order to discuss your personal information. This includes patients 18 years of age, even though they still may be covered under their parents' insurance plan and the parents are still paying their bill, the patient must list their parents on this paper. Keep in mind, **THIS IS FOR YOUR PRIVACY AND PROTECTION**, and we will do everything that we can to keep your information safe and secure. If you have any questions, or would like a more detailed explanation of this form, please do not hesitate to ask any one of our staff members.

- In regards to your account, who may we discuss information with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

[ ] Upcoming Appointment Information
[ ] Treatment Information
[ ] Financial Information
[ ] I do not want you to discuss ANY information with ANYONE, other than myself

- In regards to leaving voice-mail messages, may we discuss:

[ ] Upcoming Appointment Information
[ ] Treatment Information
[ ] Financial Information
[ ] I do not want you to discuss ANY information on my voice-mail

Print:_____ Sign:_____ Date_____