

### Medical History

Physician \_\_\_\_\_ Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Are you in Good Health? \_\_\_\_\_  
 If no, explain \_\_\_\_\_  
 Do you have an existing illness \_\_\_\_\_ If yes Explain \_\_\_\_\_  
 Have you been Hospitalized in the last two years? \_\_\_\_\_  
 Do you bleed excessively when cut? \_\_\_\_\_  
 Are you taking Medication, Pills, or Drugs? If Yes List: \_\_\_\_\_  
 Do you, or have you ever had any of the following problems?

	Y	N
Heart Disease		
High Blood Pressure		
Blood Disease		
Rheumatic Fever		
Heart Murmur		
Diabetes		
Stroke		
Epilepsy		
Arthritis		
Tumor History		
STD		
Nervous Disorders		
Radiation Treatment		

	Y	N
Liver Disease		
Kidney Disease		
Hepatitis		
Are you Pregnant		
Fen-Phen		
Asthma		
Tuberculosis		
Aids of HIV		
Allergy to:		
A. Penicillin		
B Antibiotics		
C Local Anesthetics		
D Other		

### Dental History

Do you have any Dental Complaints? \_\_\_\_\_  
 When was your last full mouth x-rays? \_\_\_\_\_  
 When was your last Cleaning? \_\_\_\_\_  
 Have you been instructed in the prevention of Decay? \_\_\_\_\_  
 Have you been instructed in caring for you gums? \_\_\_\_\_  
 Do you need to be Premedicated? \_\_\_\_\_

### Remarks

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Policy

It is your responsibility to know what your insurance benefits are. While we as an office will do whatever we can to help, please understand that we are not party to your insurance company or employer. While we are "in network" for quite a few different insurance companies, we are merely a provider of service. We are more than happy to file a claim on your behalf, and even send x-rays if necessary, but if for some reason your insurance has denied payment on treatment that has been provided, it is your responsibility to find out why.

I hereby authorize payments from my insurance benefits to my account with AVDA. I understand that I am responsible for the cost of all dental treatment rendered. I agree to be responsible for all charges and material not paid by my dental benefit plan to the extent permitted under applicable law. I authorize the release of any information relating to my dental treatment or personal information.

Signature \_\_\_\_\_ Date \_\_\_\_\_