MEDICAL HISTORY

Please complete both sides.

Name: ______________________________ **Date:** __________
Last First Middle

Address: ______________________________
Street Apt./Box City State Zip Code

Phone: ______________________ **Occupation:** ______________________
Home Work

Date of Birth: __________ **Sex: M F Height:** ________ **Weight:** ________ **Married? :** _____

SSN#: _____ - ____ - ______ **Name of Spouse:** ______________________

Nearest Relative: ______________________ **Phone:** __________

If you are completing this form for another person, please give your name and that person's relationship to you.

Name: ______________________ **Relationship:** __________

Reason for visit: ______________________ **Referred by:** __________

Employer: ______________________________
Name Address City State Zip Code Phone

Insurance Company: ______________________ **Policy Number:** __________

Although dental personnel primarily treat the area in and around your mouth, your mouth is one part of your entire body. Any health problem you are experiencing or medication which you may be taking could have an important bearing on the dentistry which you will receive. Thank you for answering these questions.

ALL RESPONSES REMAIN CONFIDENTIAL.

Medications (prescribed or over-the-counter) you are taking: ______________________

____

Allergies: ______________________________

Serious illnesses, operations, or hospitalizations (within the last five years): __________

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____

Any changes in your health (within the last year): ______________________

____

Your Physician: ______________________ **Date of last physical:** __________
Name Phone

Circle any condition which applies to your past or present health.

Heart Murmur	Hepatitis	Tumors	AIDS
Heart Attack	Jaundice	Growths	HIV
Damaged Heart Valves	Liver Disease	Cancer	Immunosuppressive Disease
Congenital Heart Defect		Rheumatic Fever	Venereal Disease
	Epilepsy		
High Blood Pressure	Seizures	Tuberculosis	**ALLERGIES**
Stroke	Fainting Spells	Arthritis	Penicillin
Angina		Depression	Aspirin
Heart Problems	Blood Transfusions	Nervous Breakdown	Codeine
Pacemaker	Hemophilia		Local Anesthetics
	Abnormal Bleeding	Diabetes	Other ____________
Asthma	Blood Disorders	Kidney Trouble	
Hay Fever		Stomach Ulcers	**WOMEN**
Hives			Pregnant (currently)
Sinus Problems			Nursing

Describe any disease, condition, or problem not listed above which you feel may be important for me to know about as I plan your course of treatment.

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INSURANCE AUTHORIZATION

I hereby authorize payment of insurance benefits directly to Dr. Christopher Scalia, D.D.S.

Signature of insured: ______________________ **Date:** ____________

I have reviewed the attached treatment plan. I authorize the release of any and all information relating to any claim resulting from that treatment.

Signature of Patient: ______________________ **Date:** ____________

(If patient is a minor, authorization must be signed by parent or legal guardian.)

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions which I may have made in the completion of this form.

______________________ ______________________

(Signature of person completing form.) (Signature of Dentist)