ADULT MEDICAL HISTORY UPDATE

Drs. Fussell, Humphreys, Humphreys & Harrell, P.A.

Date: ______________________________

Name: Mr. Mrs. Ms. Dr. ______________________________
(LAST) (FIRST) (MI) (PREFERRED)

Birthdate: ____________ Age: ____________ S.S. #: ______________ County ____________ Male ❑ Female ❑

Mailing Address: ______________ City: ____________ State: ________ Zip: ____________

Physical Address: ______________ City: ____________ State: ________ Zip: ____________

Home Phone: ____________ Work Phone: ____________ ext. ________ Cell Phone: ____________

Best Daytime Contact Number: ______________________________

Email: ____________ Choose preferred method of confirming appointment: ❑ Email ❑ Text ❑ Telephone

Employer: ______________________________

Emergency Contact: ______________ Relationship: ______________

Home Phone: ____________ Work Phone: ____________ ext. ________ Cell Phone: ____________

Dental Insurance Information

Insurance Company Name: ______________________________

Group #: ____________ Name and date of birth of Policy Holder: ______________

Relationship: ____________ Policy Holder's Social Security Number/ ID Number: ______________

Policy Holder's Employer: ______________________________

Medical Information

Primary Physician's Name: ______________ Phone: ____________

Pharmacy ______________ Phone: ____________

List any medications or supplements that the patient is currently taking: ______________

Have you ever been told you require premedication with antibiotics prior to dental treatment? ❑ Yes ❑ No

I authorize permission to discuss premedication with family member or leave message. ❑ Yes ❑ No

Are you aware of an allergic or adverse reaction to any medication or substance? ❑ Yes ❑ No ______________

Are you being treated or ever been treated for:

An abnormal heart condition of any kind? .... ❑ Yes ❑ No

Specify ______________________________

Cardiac transplant? .... ❑ Yes ❑ No

Congenital heart disease? .... ❑ Yes ❑ No

Bacterial endocarditis? .... ❑ Yes ❑ No

Artificial heart valve? .... ❑ Yes ❑ No

Hepatitis [ ] A (infectious), [ ] B (serum), [ ] Other ❑ Yes ❑ No

Artificial joints (hip, knees, shoulders, etc.)? .... ❑ Yes ❑ No

Kidney disease/Dialysis? .... ❑ Yes ❑ No

Arthritis/Rheumatism? .... ❑ Yes ❑ No

Rheumatic fever .... ❑ Yes ❑ No

High Blood Pressure? .... ❑ Yes ❑ No

Diabetes? .... ❑ Yes ❑ No

Thyroid disease/problems? .... ❑ Yes ❑ No

Respiratory disease/problems? .... ❑ Yes ❑ No

Neurologic disorders? .... ❑ Yes ❑ No

Liver disease? .... ❑ Yes ❑ No

Venereal disease? .... ❑ Yes ❑ No

A.I.D.S., or H.I.V. positive? .... ❑ Yes ❑ No

Epilepsy or Seizures? .... ❑ Yes ❑ No

Anemia? .... ❑ Yes ❑ No

Abnormal bleeding from a cut? .... ❑ Yes ❑ No

Allergic skin reaction to metal jewelry .... ❑ Yes ❑ No

Females: Are Your Pregnant? .... ❑ Yes ❑ No

(Over)

PATIENT CONSENT FOR TREATMENT

I understand that the information contained in the Medical History Update is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I authorize permission to discuss premedication treatment, or account information by phone, fax, e-mail, or in person to assist the practice to carry out treatment. The undersigned hereby authorizes Drs. Fussell, Humphreys, Humphreys & Harrell to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I understand that using anesthetic agents embodies a certain risk. All diagnostic aids and documentation are the property of the practice. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another healthcare provider.

I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

____

Signature   Date

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, and due payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1½% per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note. I agree to any inquiries as deemed necessary to establish credit with the office, including a formal credit review. I hereby authorize payment of my dental insurance benefits directly to Drs. Fussell, Humphreys, Humphreys & Harrell, P.A. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Fussell, Humphreys, Humphreys & Harrell, P.A. may decline to provide treatment to me.

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Print Name of Patient

____

Signature of Patient/Guardian

____

Date