**Coral Reef Dental**

Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

1. Are you having pain or discomfort at this time? Yes No

2. Do you feel very nervous about having dentistry treatment? Yes No

3. Have you ever had a bad experience in a dental office? Yes No

4. Have you been a patient in the hospital during the past 2 years? Yes No

5. Have you seen a medical doctor during the past 2 years? Yes No

6. Have you taken any medicine or drugs in the past 2 years? Yes No

7. Are you allergic or made sick by penicillin, aspirin, codeine or any drugs or medications?

(i.e., itching, rash, swelling of hands or feet or eyes) Yes No

8. Have you ever had any excessive bleeding requiring special treatment? Yes No

9. Has your medical doctor ever said you have cancer or a tumor? Yes No

10. Have you had any recent surgeries or anesthesia? Yes No

11. Have you had any complications resulting from a surgery or anesthesia? Yes No

12. Do you smoke? Yes No

13. Women: Are you pregnant now? Yes No

Physicians Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical History Review

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**Circle any of the following which you have had or have at the present time:**

Heart Failure Heart Disease or Attack Angina Pectoris High blood pressure

Heart Murmur Rheumatic Fever Congenital Heart Lesions Scarlet fever

Artificial heart valve Bruise easily Heart Pacemaker Heart surgery

Artificial Joint Anemia Stroke Kidney Trouble Pain in Jaw Joints

Emphysema Cough Tuberculosis (TB) Asthma Hay Fever

Sinus Trouble Allergies or hives Diabetes Thyroid Disease

Ulcers Chemotherapy Arthritis Rheumatism

Cortisone Medicine Glaucoma Sickle Cell Disease Liver Disease

AIDS Hepatitis A, B, C Drug Addiction Yellow Jaundice

Blood Transfusion Hemophilia Venereal Disease Syphilis, Gonorrhea

Cold Sores Genital Herpes Epilepsy or Seizures Fainting or Dizzy Spells

Nervousness Psychiatric Treatment

Do you have any disease, condition or problem not listed? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever had a change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

I understand I remain personally responsible for the total amount due for the services I receive at Coral Reef Dental, regardless of the existence of any private dental insurance policy. Coral Reef Dental may at any time, demand payments from me immediately upon rendering service, or at any time thereafter at his option.

I understand that Coral Reef Dental will attach a 1 1/2% monthly interest charge on any balance which remains unpaid after thirty (30) days. I understand Coral Reef Dental may, at option, pursue this matter into litigation and that the prevailing party will be entitled to an award of attorney's fees and court costs associated with such collection fees.

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Signature of Patient, Parent, Guardian