

## Medical History

The following information is to be reviewed by Timothy Schafer, D.D.S. and will be held in strictest confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat you, according to your general health and well-being.

	Yes	No
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>
Name of physician _____ Phone # of physician _____ Specialty _____		
Have you been hospitalized, or had a major illness, operation, or injury in the last 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>
Explain _____		

Please list all drugs or medication you are currently taking, including over the counter drugs. \_\_\_\_\_

Are you allergic to any medication or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes please name and describe allergies. _____		
Have you had any abnormal bleeding associated with surgery or trauma? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any blood disorders such as anemia? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of heart disease or cardiovascular disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
(Such as high blood pressure, heart attack, artificial heart valves, stroke, etc.)		
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Rheumatism (painful, swollen joints) .....	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or cough up blood .....	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
HIV & AIDS or other immunosuppressive disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>
Other .....		

Agreement: I agree to pay for all professional fees at the time of service or my portion not covered by Dental Insurance for myself or the above patient. I realize I am also responsible for full payment of fees not paid by my insurance. I understand that should my account become past due it may be placed with a collection agency. If it is, I am responsible for all collection agency fees (33 1/3% of my account balance), attorney fees and court costs. For example: a balance of \$100.00 would become \$133.33 if placed with a collection agency. I hereby authorize insurance payment directly to Post Road Family Dentistry, P.C.

Signature: \_\_\_\_\_

Printed Name \_\_\_\_\_