



**Medical Alert:**

PATIENT \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

(PLEASE PRINT)

Male \_\_\_\_\_ Female \_\_\_\_\_

PATIENT NAME: FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ SSN # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

E-MAIL \_\_\_\_\_ EMPLOYER \_\_\_\_\_

NAME OF PHYSICIAN & PHONE NO \_\_\_\_\_ DATE OF LAST PHYSICAL \_\_\_\_\_

HOW DID YOU HEAR ABOUT US \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

**DO YOU HAVE A HISTORY OF:**

	YES	NO		YES	NO		YES	NO		YES	NO
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	LUPUS	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Are there any problems not listed that you would like to discuss?		
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>			
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			

List any medications you are taking including non-prescription drugs \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

**DENTAL INFORMATION**

1. Date of last dental visit: \_\_\_\_\_

On a scale of 1 – 10 with 10 being the highest rating:  
How important is your dental health to you?

2. If wearing dentures, age of dentures: \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 3. Do your gums bleed when brushing or eating       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you ever clench or grind your teeth?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are your teeth sensitive to hot, cold, pressure? | <input type="checkbox"/> | <input type="checkbox"/> |

If I could change my smile, I would make my teeth:

YES NO

**WOMEN** YES NO

Is there a possibility of pregnancy?  YES  NO

Estimated delivery date \_\_\_\_\_

Are you nursing?  YES  NO

Are you taking birth control pills?  YES  NO

**WOMEN NOTE:** Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Whiter  YES  NO

Straighter  YES  NO

Close space  YES  NO

Replace black mercury fillings with tooth colored restorations  YES  NO

Repair chipped teeth  YES  NO

Replace missing teeth  YES  NO

Less gum showing  YES  NO

Replace old crowns or caps that don't match  YES  NO

Do you prefer to save your teeth?  YES  NO

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

Signature of Patient (parent or guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Health History Reviewed by: \_\_\_\_\_ Dentist Signature \_\_\_\_\_

**Midwest Dental Associates**  
**1677 Montgomery Rd.**  
**Aurora, IL 60504**

---

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

---

Patient name \_\_\_\_\_

Patient number \_\_\_\_\_

Patient address \_\_\_\_\_

Patient phone number \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

**I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.**

Dated \_\_\_\_\_ Patient signature \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_