Medical Health History & Patient Information



Address:	Address: Email ALLERGIES: Are you Penicillin Latex If yes, please explain: GENERAL HEALTH:								Married	Sir	nale	Othe	
Adulters: Social Security #	Address: Email ALLERGIES: Are you Penicillin Latex If yes, please explain: GENERAL HEALTH:									arriedSingle		_0016	∍r_
ALLERGIES: Are you allergic to any of the following? Mark with an X after condition(s) Penicillin Sulfa Codeine Seasonal Latex Aspirin Anesthetics Other:	ALLERGIES: Are you Penicillin Latex If yes, please explain: GENERAL HEALTH:												
Penicillin	Penicillin Latex If yes, please explain: GENERAL HEALTH:	allergic											
Penicillin Sulfa Codeine Seasonal	Penicillin Latex If yes, please explain: GENERAL HEALTH:		to any of the	following	? Mark w	vith an X after o	ond	tion(e)					_
If yes, please explain: GENERAL HEALTH: Mark with an X after condition(s) Hospitalized or Major Operation Medications Herbal Supplements Antibiotic FreMedication Prior to dental treatment Drugs Drugs Prior to dental treatment Drugs Dru	lf yes, please explain: GENERAL HEALTH:			Sulfa					T	Seasonal			_
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Medications													
MOMEN, ARE YOU Mark with an X after condition(s) Pregnant Trying to Get Pregnant Nursing Taking Birth Control HEALTH CONDITIONS: Mark with an X after condition(s) Chest Pain Cancer: Type: Alzheimers / Dementia Sinus Issues/ Surgery Congenital Heart Disease Radiation Treatments Rheumatic Fever STD Heart Attack Chemotherapy Glaucoma HIV/ AIDS Heart Pacemaker Tumcrs Blood Disorder/ Disease Herpes Mitral Valve Prolapse Liver Disease Arthritis Cold Sores / Fever Blisters Artificial Heart Valve Kidney Disease Acid Reflux PTSD Heart Murmur Ulcers Emphysema Eating Disorder Cardiac/ Organ Hepatitis: Blood Transfusion Autism Transplant A / B / C High Blood Pressure Asthma Diabetes: Type I or II ADHD Stroke Autoimmune disease Stomach / Intestinal Disease Depression Joint Replacement Tuberculosis Epilepsy / Seizures Anxiety Headaches / Migraines Bruise Easily Hearing Impaired Thyroid Disease Type: Chronic Cough Cortisone Medication Fainting / Dizzy Spells / Vertigo Other: DENTAL CONCERNS: Do you experience any of the following? Mark with an X after condition(s) Pain / Sensitivity Dry Mouth Clenching or Grinding Bleeding while brushing Stained teeth													
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					leeding w								_



DENTAL INSURANCE INFORMATION

PRIMARY	SECONDARY
EMPLOYER	EMPLOYER
Subscriber:	SUBSCRIBER:
Subscriber Birthdate:	Subscriber Birthdate:
ID/SSN	ID/SSN
Company:	Company:
Cancellation Policy: We require at least 2	24 hours notice to cancel an appointment or you will incur a \$50 late notice
fee. The fee will also apply to missed appointments.	INITIAL:
PHOTO RELEASE: I	the undersigned do hereby authorize and
consent to the use of photographs/x-rays of	of me taken by [Scheier & Price Family Dentistry]. I do consent
to the use of my photographs or images for	r marketing materials including website, social media and
patient education for (Scheier & Price Fami	
Patient's Name:	
	Date:
HIPAA: I have reviewed or received a cor	by of this office's Notice of Privacy Practices.
Print Name:	Date:
SIGNATURE (Parent/Guardian signature for	minor):
If this Acknowledgement is signed by a pers following:	sonal representative on behalf cf the patient, complete the
l give permission for Scheier Family Den	itistry to discuss treatment.
Pre-authorization and account with:	,
Relationship to Patient:	
Signature	Date