# Medical History

Dr. Robert R. Hallman
Monteith Commons
2915-C Piedmont Road
Atlanta, Georgia 30305
404.262.3231

Date: _____

Patient's Name: _____ _____ ___ _____
Last (Mr./Mrs./Ms./Dr.) First MI Preferred

Physician's Name: _____ Phone #: _____

Address: _____
Street City State Zip Code

**For the following questions, *circle yes or no*. Your answers are for our records only and are strictly confidential. Please note that during your initial visit you will be asked some questions about responses to this questionnaire, and there may be additional questions concerning your health**.

1. Has there been any change in your health in the past year? ..... Yes No
2 My last physical exam was on _____
3. Are you now under the care of a physician? …… Yes No
   If so, what medicine(s) are you taking? _____

_____

_____
**Continue on back of page if necessary**

4. Do you take nonprescription drugs, supplements, herbals or homeopathies?. ...…… Yes No
   If so, what are you taking? _____

_____

_____
**Continue on back of page if necessary**

5. Have you had any serious illness, operation or been hospitalized? …….. Yes No
   If so, what was the illness or problem? _____

_____

6. Do you have or have you had any of the following diseases or problems?

A. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease…….. Yes No

B. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ……. Yes No

1. Do you have chest pain upon exertion? ..…… Yes No
2. Are you ever short of breath after mild exercise or when lying down? ……. Yes No
3. Do your ankles swell? ……. Yes No
4. Do you have any inborn heart defects? Heart murmur? ..... Yes No
5. Do you have a pacemaker? …… Yes No
6. Do you have an artificial joint(s) or heart valve? …… Yes No

If yes, what medication, if any, do you take for this? _____

_____

Is premed required prior to dental work? _____ Yes No

7. Do you use blood thinners?_____ Yes No

C. Allergy ……. Yes No

If yes, to what?_____

_____

_____

D. Sinus trouble……... Yes No

E. Asthma or other breathing problem …….. Yes No

If yes, do you use an inhaler? …… Yes No

F. Fainting spells or seizures …….. Yes No

G. Persistent diarrhea or recent weight loss …… Yes No

H. Diabetes...…….. Yes No

I. Hepatitis, jaundice or liver disease... ……. Yes No

J. AIDS or HIV infection…… Yes No

K. Thyroid problems……. Yes No

L. Respiratory problems……. Yes No

M. Arthritis or painful swollen joints…….. Yes No

N. Stomach ulcer, hyperacidity or other stomach problem……... Yes No

O. Kidney trouble……. Yes No

P. Liver problems……. Yes No

Q. Tuberculosis……. Yes No

R. Persistent cough or cough that produces blood…… Yes No

S. Persistent swollen glands in the neck…… Yes No

T. Low or high blood pressure…….. Yes No

U. Sexually transmitted disease…… Yes No

V. Epilepsy or other neurological disease……. Yes No

W. Problems with mental health…… Yes No

X. Cancer……... Yes No

1. Have you ever had radiation treatment, chemotherapy
for a tumor, growth or other condition?..... Yes No
If yes, explain _____

_____

Y Problems with immune system.....…… Yes No
Z. Do you have a history of bulimia or anorexia……. Yes No

7. Have you had abdominal bleeding? ..... Yes No
Have you ever required a blood transfusion? ..... Yes No
8. Do you have any blood disorders such as anemia, leukemia, etc? ..... Yes No
9. Are you on blood thinners? ..... Yes No
10. Have you ever had any treatment for a tumor or growth? ..... . Yes No
If yes, explain: _____

11. Are you allergic or had a reaction to:
A. Local anesthetics……. Yes No
B. Penicillin or other antibiotics…….. Yes No
C. Sulfa drugs……. Yes No
D. Barbiturates, sedatives or sleeping pills…….. Yes No
E. Aspirin…….. Yes No
. If take, how often? _____

F. Iodine……..... Yes No
G. Latex…… Yes No
H. Metals…… Yes No
I. Tetracycline…… Yes No

12. Do you smoke, chew, use snuff or any other forms of tobacco? ..... Yes No
13. Have you ever had any serious trouble associated with any previous dental
treatment? ..... Yes No
If so, explain_____

_____

14. Do you have any disease, condition or concern not listed above that you think I
should know about? …….. Yes No
If so, explain_____

_____
15. Would you like to speak to the doctor privately about any problem? ..... Yes No
16. Are you wearing contact lenses? ..... Yes No
17. Are you wearing removable dental appliances? ..... Yes No
18. Are you hearing impaired? …….. Yes No

WOMEN

19. Are you pregnant…… Yes No

If yes, due date? _____ Yes No

## Authorization

To the best of my knowledge, all the preceding dental and medical information is true and correct. If I ever have a change in my health, I will inform this office at my next dental appointment without fail. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required for proper care.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payors and/or healthcare practitioners.

I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance. I further consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

I consent to the use of appropriate medication and therapy as deemed necessary and fully understand that using anesthetic agents embodies certain risk.

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or other member of the staff responsible or any error or omissions that I may have made in completion of this form. I understand that these questions are held in privacy. I request that you contact me by whatever means necessary to keep me updated on my dental health.

In addition, I understand that thirty six (36) hour notice is required to change an appointment without incurring a charge, unless there is an emergency. Also, a 1.33 % finance charge (16% annually) will be added to any balance over 30 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature_____Date_____

Parent or responsible party signature if applicable_____

Relationship to patient_____Date_____