PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height: ☐
For Office Use Only		BP ☐ Heart Rate: ☐	Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

smile
by Dr. John Paul

Dental History

Name_____ **Date**_____

What is your primary reason for coming here? _____

When was your last dental visit? _____

Do any of the following hurt your teeth? Hot ❑ Cold ❑ Sweets ❑ Chewing ❑

How often do you brush your teeth? _____ Do your gums bleed when you brush your teeth? _____

Does your partner say you snore loudly and stop breathing during the night? _____

Do you drink alcohol or smoke? _____

Is your neck size greater than 171/2 inches (for a man) or 15 inches (for a woman)? _____

Are you often sleepy during the day, or do you fall asleep during inappropriate times such as at work or while driving?

_____

Do you clench or grind your teeth? _____

Do your jaws click or pop? _____ For how long? _____

Do you have frequent headaches? _____ Earaches? _____

Can you chew on both sides of your mouth? _____

Have you ever had braces on your teeth? _____ When? _____

Do you usually have many cavities? _____ Broken fillings? _____

Do you have any loose teeth? _____ Broken teeth? _____

Do you notice any wear to your teeth? _____ Food traps? _____

Do you have any restorations you are not happy with? _____

How do you feel about the appearance of your smile? _____

Is there anything in particular we can do to make your visits more pleasant? _____

_____

Please add anything you feel is important.

_____

_____

smile
by Dr. John Paul
John H. Paul, DMD, PA
2024 Edgewood Drive South
Lakeland, FL 33803

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for John H. Paul, DMD, PA the _____ day of _____. 2017. A copy of this signed, dated Acknowledgment shall be as effective as the original.

_____

_____
Name (Please Print)

_____ _____
Signature Date

If you are the legal representative of the patient, please print the patients' name and describe your authority.
_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Kristy Gabel.

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with pt. _____
The patient refused to sign _____
The patient was unable to sign _____
Other (please describe) _____

_____
Signature of Privacy Officer

smile

by Dr. John Paul

Due to the increase in the amount of time it takes dental insurance companies to reimburse our office for services performed we want you, the patient, to know that we will no longer be able to wait indefinitely for payment.

We will continue to submit your insurance claims, after you have paid your deductible and co-pay, if applicable; however we will only wait 45 days for reimbursement. After that time the full responsibility of your balance will fall on you.

We will do everything possible to assist you in obtaining your refund from the insurance company. If you need insurance forms, x-rays etc. you only need to ask.

I have read and understand the above information and I agree to pay my balance after 45 days if the insurance has not paid their portion.

Patient

Signature_____Date_____