

MEDICAL HISTORY

Change of address or phone number YES/NO _____ Date _____
We would like to take the opportunity to bring your medical history up to date. Email _____
Name _____ Date of Birth _____
Male/Female _____ Home Phone _____ Cell Phone _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Date of last medical exam _____ Reason _____
Have you been under the care of a doctor anytime during the last three years? _____
Name of usual physician _____ Name of dental insurance co. _____
Other physical conditions _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Please List Allergies
_____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancies | <input type="checkbox"/> Sickle Cell Trait |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | Due Date: _____ | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Have you ever taken |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | Bisphosphonate (Fosamax, |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | Boniva, Actonel) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> LIST CURRENT MEDS: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis Type: _____ | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | _____ |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors | _____ |
| | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | _____ |

I have been given access to this office's Notice of Privacy Practices and the Financial Guidelines.

Signed _____

Signature on File Authorization

I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me, directly to the below named dentist or dental entity.

Guy G. Levy, D.D.S. and Corinne R. Hoffman, DDS
1320 Kiln Creek Parkway, Suite L Yorktown, VA 23693

_____ Date _____
Patient Signature

_____ Date _____

_____ Date _____

_____ Date _____