MEDICAL HISTORY

FOR

1754--Time Off

Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No _____

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Stroke ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Liver Disease ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Lung Disease ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pace Maker ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Steven A. Rock D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Rock _____

Telephone: 708-848-2033 _____ Fax: 708-8484-6368_____

E-mail: _____

Address: 1515 Harlem Ave. Suite 107, Oak Park, IL. 60302_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Name: _____ Today's Date: ____/____/____

Date of Birth: _____/_____/_____ SS#: _____/____/_____

Address: _____ City:_____

State:_____ Zipe:_____

Home Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____

Insurance Company: _____ Group #: _____

Insurance Address: _____ City: _____

State: _____ Zipe: _____

List Any Family Member Covered By This Insurance: _____

_____

Employer's Name: _____

Employer's Address: _____ City: _____

State: _____ Zipe: _____

List ANY Medications You Are Currently Taking: _____

_____

_____

Have You Had Any Surgeries Since Your Last Visit? _____ If Yes, What? _____

_____

_____

_____

Steven A. Rock D.D.S.

1515 N. Harlem Ave. Oak Park, IL 60302

Phone: (708) 848-2033 or Fax: (708) 848-6368