PATIENT MEDICAL HISTORY

1. Are you now or have you been under the care of a physician during the last 5 years? Yes ☐ No ☐
Why? _____

2. Do you take any medicine regularly including over-the-counter and prescription drugs? Yes ☐ No ☐
If yes, what?

3. Do you have a bleeding problem? Yes ☐ No ☐ Do you take anticoagulants (blood thinners) such as aspirin or Coumadin? Please list:_____

4. Have you ever taken a medication such as Fosamax, Zometa, Actonel, Boniva, Didronel, Skelid, Aredia, Reclast, Bonefos, Prolia, Xgeva, Sutent (Sunitinib) to increase bone density? Other_____

5. Were you ever hospitalized for a major illness and/or operation? Yes ☐ No ☐

What?_____

When?_____

Where?_____

6. Have you ever had a general anesthetic? _____ If yes, any difficulties? _____

7. Patient's Height_____Weight_____Age_____

8. Are you now or have you ever been treated for any of the following? Please check yes or no on each line.

Yes	No		Yes	No		Yes	No	
☐	☐	Heart or Blood Vessels	☐	☐	Liver	☐	☐	Long Standing Sore or Swelling
☐	☐	High or Low Blood Pressure	☐	☐	Kidneys	☐	☐	Stomach Ulcer
☐	☐	Stroke	☐	☐	Dialysis	☐	☐	Eyes or Glaucoma
☐	☐	Heart Murmur	☐	☐	Thyroid	☐	☐	Previous TMJ problem
☐	☐	Enlarged Heart	☐	☐	Lungs			(Clicking or Popping in Joint)
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Mental Health Disorder
☐	☐	Heart Valve Replacement	☐	☐	Asthma/Emphysema	☐	☐	Radiation or X-ray Treatment
☐	☐	Other Heart Surgeries	☐	☐	Hay Fever	☐	☐	Are You Pregnant? Months_____
☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems	☐	☐	Taking Birth Control
☐	☐	Blood or Lymph Glands	☐	☐	Chronic Cough	☐	☐	Do You Wear Dentures
☐	☐	Hepatitis	☐	☐	Shortness of Breath	☐	☐	Do You Have Capped Teeth
☐	☐	Anemic/Low Blood Count	☐	☐	Do You Smoke___PPD	☐	☐	Do You Have Loose Teeth
☐	☐	Diabetes	☐	☐	Epilepsy/Convulsions	☐	☐	Sleep Disorder
☐	☐	Cancer	☐	☐	Joint Replacement	☐	☐	Other_____

9. Have you ever used or do you currently use Suboxone or any illegal drugs such as steroids, cocaine, heroin or marijuana? Yes ☐ No ☐

11. Are you sensitive or allergic to latex or any drug such as penicillin, aspirin, novocaine, codeine or other? _____ Yes ☐ No ☐

12. Have you ever had difficulties with dental treatment or local anesthesia? Yes ☐ No ☐
If yes, please explain _____

13. Reason for today's visit: (please explain)

Date _____ Signed _____

PATIENT INFORMATION (PLEASE PRINT)

(Mr., Mrs., Ms.)_____ Patient Name _____Sex: M F

Mailing Address_____City_____State_____Zip_____

Phone Numbers Home_____Business _____Cell_____

Date of Birth_____Age_____ Social Security #_____

Dentist_____Orthodontist_____Physician_____Referred By_____

Occupation_____Place of Employment_____

Spouse_____ Social Security #_____

Emergency Contact Name and Phone_____

Pharmacy_____Phone #_____Location_____

INSURANCE INFORMATION

Medical Insurance_____

Subscriber Name_____

SS#_____

Date of Birth_____

Dental Insurance_____

Subscriber Name_____

SS#_____

Date of Birth_____

PARENT/GUARDIAN INFORMATION

Mother_____Father_____Other_____

Name_____HomePhone_____WorkPhone_____

Address_____Birth Date_____

Employer_____Social Security #_____

COLLEGE STUDENT

Name of School_____Address_____

Graduation Date_____Part Time_____ Full Time_____

We make every effort to keep down the cost of your oral surgical care. Payment is expected upon completion of each visit. If you have an insurance that our office is not participating with, after payment in full for services, a coded statement will be given to you so you can bill your insurance directly for your reimbursement.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **General anesthesia is not always a covered benefit. It is your responsibility to pay any deductible, co-insurance, charges for non-covered procedures (in some instances general anesthesia) or any other balance not paid for by your insurance company. A fee will be charged to your account for any returned checks.**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment of insurance benefits to this treating doctor, that otherwise would have been payable to me.

Signature_____Date_____

CALLAHAN AND BERGEY ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I can request a copy of this office's Notice of Privacy Practices and that the Notice of Privacy Practices is accessible in the waiting room.

E-MAILING X-RAYS TO YOUR DENTIST

X-rays emailed from this office to your Doctor/Dentist will NOT be encrypted. Your name is the only other personal information that is attached to your x-ray. Callahan and Bergey Associates cannot guarantee, but will use reasonable means to maintain the security and confidentiality of email sent and received. We take appropriate precautions when transmitting email to avoid unintentional disclosures, such as verifying email address for accuracy before sending. The Practice is not liable, however, for improper disclosure of confidential information that is not caused by our unintentional misconduct. Prior to giving your consent, it is important for you to be aware of the inherent risks of sending and receiving confidential information by e-mail, (i.e., email messages can be intercepted, circulated, altered, forwarded, stored or used without authorization or detection)

_____**YES** email x-rays _____**DO NOT** email x-rays

FAMILY MEMBER WE CAN RELEASE INFO TO

Name_____Relationship_____

Name_____Relationship_____

_____

PATIENT or Guardian Signature Print Name

_____

Relationship to Patient Date