# Medical History

Name________________________________________ Today's Date:____________________

Date of Birth____________________ Height________ Weight________

Physician's Name, address, and phone:_________________________________________________________

Date of last physical: __________________

**Please circle YES or NO if you have any of the following diseases, conditions, or procedures**

**Y N** Abnormal bleeding/Hemophilia
**Y N** ADD/ADHD
**Y N** Allergy
**Y N** Anemia
**Y N** Anxiety
**Y N** Arthritis/Inflammatory Rheumatism
**Y N** Asthma/Hay fever
**Y N** Autism
**Y N** Cancer/Chemotherapy/Radiation
**Y N** Cardiovascular Disease/ Heart Attack/AFIB/Stent
**Y N** Chest pain upon exertion
**Y N** Diabetes (Type ____)
**Y N** Digestive(Ulcers/Colitis)
**Y N** Epilepsy
**Y N** Fainting/seizures
**Y N** Heart Murmur
**Y N** Hepatitis (Type ____)
**Y N** High blood pressure
**Y N** Hives/Skin Rash
**Y N** Immune Defic. (AIDS/HIV/ARC)
**Y N** Jaw Problems TMJ/TMD
**Y N** Jaundice/Liver Disease
**Y N** Kidney/Organ Problems
**Y N** Migraines
**Y N** Pacemaker or any implanted medical devices
**Y N** Rheumatic Fever
**Y N** Shortness of Breath
**Y N** Sinus Trouble
**Y N** Sleep Apnea/CPAP
**Y N** Stroke
**Y N** Serious Surgeries/operations
**Y N** Tuberculosis
**Y N** Venereal Disease

If **YES** to any of the above, please explain: ____________________________________________________________

____________________________________________________________________________________

**Y N** Do you have any disease or condition not listed above that we should know about? ______________________________

____________________________________________________________________________________

**Y N** Artificial heart valves, rheumatic fever, damaged heart valves? ____________________________________________

**Y N** Have you had any orthopedic total joint replacement (e.g. hip/knee/shoulder/elbow)? If yes, which joint(s), dates, complications:

____________________________________________________________________________________

**Y N** Have you ever been advised that you need to take an antibiotic prior to dental treatment?

**Y N** Have you taken or are you scheduled to begin taking ORAL bisphosphonates (e.g. Alendronate, Fosamax, Ibandronat, Boniva, Risedronat, Actonel) or INTREVENOUS bisphosphonates (e.g. Reclast, Pamidronate, Aredia, Zoledronic Acid, Zometa)? If yes, which drug, how long, and for what condition______________________________________________________

**Y N** In the past 2 years, have you taken or currently taking steroids (e.g. cortisone). If yes, which steroid and dose?

____________________________________________________________________________________

**Y N** Are you pregnant or nursing? If pregnant, how many months?________

**Y N** Have you had any serious complications with dental treatment?___________________________________________

**Y N** Are you currently taking any blood thinners (e.g. Eliquis, Coumadin, Warfarin, Xarelto, Pradaxa)?_____________________

**Y N** Have you ever had any abnormal bleeding associated with extractions, surgery, or trauma? __________________________

**ALLERGIES:**

**Y N** Latex
**Y N** Local Anesthetics: ______________________
**Y N** Codeine or other narcotics:________________
**Y N** Antibiotics :___________________________
**Y N** Sulfa drugs: ___________________________
**Y N** Sedatives or sleeping pills: ________________
**Y N** Iodine
**Y N** Aspirin
**Y N** Shellfish
**Y N** Other: ______________________________

**Y N** Do you use tobacco products? If yes, please specific type and how many per day _______________

**Y N** Do you use drugs or other substances for recreational purposes? If yes, type and frequency ______

**CURRENT MEDICATIONS**

(Please list all drugs or medications including prescribed, over the counter, and herbal remedies):

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**DENTAL HISTORY**

**Y N** Previous periodontal care

**Y N** Previous orthodontic care (e.g. braces, Invisalign)

**Y N** Do you have regular routine dental care?

How often do you have your teeth cleaned? ______________________

**Y N** Has there ever been a significant lapse in your dental care? If so, how long__________________

**Y N** Do you have any anxiety regarding dental treatment?

**Chief Dental Complaint:**

_______________________________________________________________________________

_______________________________________________________________________________

**I understand the above information and guarantee that this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes.**

Signature of Patient/Guardian _________________________________

Date _________________________________

Irina Adler, DDS, MS
30 Canton St., Suite #12
Manchester, NH 03103
(603) 668-6434
www.nhdentalsurgery.com

Date:________________________

## About You

Name: (Last, First, Middle): ___________________________________________ Date of Birth___________________

Home Address (Street, City, State, & Zip): _________________________________________________________________

Mailing Address (if different than above):____________________________________________ Gender ______________

Home Phone__________________ Cell Phone____________________ Business Phone______________________

Email Address:___________________________________ Occupation: ________________________________

Person to contact in case of emergency:____________________________ Phone number___________________

Name of General Dentist: _________________________________________________________________________

Whom may we thank for referring you? ____________________________________________________________

**I hereby consent to the release of any pertinent information to other healthcare providers involved in my care**

Signature of Patient/Guardian ______________________________________

## Account Information

Person Responsible for Account
(name)____________________________________________________Relationship:________________________

Billing Address if different than above: ____________________________________________________________

## Insurance Information

**Primary Dental Insurance**: _______________________________________ Phone #______________________

Dental Insurance Address:_______________________ City___________________ State______Zip___________

Policy Holder Name:_______________________ Employer:_____________________ Group #_______________

Subscriber ID #_______________________________________ Policy Holder's DOB_____________________

**Secondary Dental Insurance**:_______________________________________ Phone #: ____________________

Dental Insurance Address: _______________________ City___________________ State______Zip___________

Policy Holder Name:_______________________ Employer:_____________________ Group #_______________

Subscriber ID #_______________________________________ Policy Holder's DOB_____________________

**I hereby consent to the release of information required for preauthorization and or payment by third parties for my treatment. I understand that my insurance is not a guarantee of payment. I understand if they do no pay on my claim, I am fully responsible for the full fee. I understand that the balance needs to be paid in 30 days. I herby authorize and direct payment of the dental benefits directly to Dr. Irina Adler.**

Signature of Patient or Guardian____________________________________ Date_________________________

## Irina Adler, DDS, MS

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________ office's Notice of Privacy Practices.

Please note: A copy of the Privacy Practice is posted in our office and we will be happy to provide you with a copy at your request

______________________________
Please Print Name

______________________________
Signature

______________________________
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

______________________________

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