HEALTH HISTORY INFORMATION

(Please Print)

Name _____ Date _____

Birthdate _____ Physician _____

Family History (Circle) Heart Disease Bleeding Disorders Diabetes Seizures

Medications taken presently or within the past 6 months especially aspirin, blood thinners or bone density medications: _____

_____

_____

Have you been hospitalized in the past 5 years? _____

If so, reason _____

Please circle Y (yes) if you have or N (no) if you have not been treated for any of the following conditions:

Heart Attack*	Y	N	Convulsions	Y	N	Cold Sores	Y	N
Rheumatic Fever*	Y	N	Fainting/Dizzy Spells	Y	N	Oral Herpes	Y	N
Allergies	Y	N	Heart Problems	Y	N	Cancer	Y	N
Hayfever	Y	N	High Blood Pressure	Y	N	Tumors/Growths	Y	N
Sinus Trouble	Y	N	Stroke	Y	N	Glaucoma	Y	N
Asthma	Y	N	Anemia	Y	N	Hepatitis A, B, C	Y	N
Mental Problems	Y	N	Hemophilia	Y	N	Liver Disease	Y	N
Emotional Problems	Y	N	Sickle Cell Anemia	Y	N	Kidney Disease	Y	N
Alcoholism/Drug Abuse	Y	N	Arthritis-Osteo	Y	N	Thyroid Disease	Y	N
Ulcers/Gastric Reflux	Y	N	-Rheumatoid			HIV (AIDS)	Y	N
Diabetes	Y	N	Osteoporosis/Penia	Y	N	Venereal Disease	Y	N
Epilepsy	Y	N	Back/Neck Problems	Y	N	Tuberculosis	Y	N
						Emphysema	Y	N

Explanation: _____

*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

Please circle Y (yes) if you have or N (no) if you have not experienced any of the following:

Prolonged Bleeding*	Y	N	Blood Transfusion	Y	N	Persistent Cough	Y	N
Heart Valve Replacement*	Y	N	Pain in the Jaws	Y	N	Radiation/Chemotherapy	Y	N
Joint Replacement*	Y	N	Unexplained Weight Loss	Y	N	Bloody/Productive Cough	Y	N

Please circle Y (yes) if you have or N (no) if you have not had an adverse reaction to any of the following:

Latex Rubber	Y	N	Sulfa	Y	N	Codeine	Y	N
Penicillin	Y	N	Aspirin	Y	N	Other (Including Food)	Y	N
Dental Anesthetics	Y	N	Barbiturates	Y	N	_____		

WOMEN: Are you pregnant? Y N If yes, date due _____

Taking Contraceptives Y N

Do you smoke/chew tobacco? Y N

Approximately, when was your last dental visit? _____ Cleaning? _____

Approximately, when were your last dental x-rays taken? _____ FMX ☐ BW ☐ Pana ☐

To the best of my knowledge, all of the above answers are true and correct.

Patient's Signature _____ Dentist's Signature _____

(parent signature if patient under 18 years old) Date _____

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Medicare Private Contract

By signing this contract I understand and agree that I will not submit (or request that my periodontist submit) a claim to Medicare or its agents for services provided by Drs. Kelly Ford & Veronica Guy, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by Drs. Kelly Ford & Veronica Guy and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the providers for services provided.

I understand that Medigap plans do not, and other health and medical care insurance plans may elect not to, make payments for such services.

I understand that I have the right to have services provided by other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted out.

I understand that Drs. Kelly Ford & Veronica Guy are not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

Patient Name: _____

Patient/Representative Signature: _____Date: _____

Provider Signature: _____Date: _____