RONALD P. CODY, D.M.D.
MEDICAL HISTORY QUESTIONNAIRE

Date_____ **Dental Insurance**_____**Email**_____

Name_____ **Home phone (____)**_____

Address_____ **Business phone (____)**_____

City_____ **State**____ **Zip code**_____ **Cell phone**_____

Occupation_____ **Social Sec No.**_____

Date of Birth__/__/__ **Sex: M F; Height**____**Weight** ____**Single**___ **Married**___**Other**___

Name of Spouse_____ **Closest Relative**_____ **Phone**_____

If you are completing this form for another person, what is your relationship to that person?
_____

Referred by_____

For the following questions, circle *yes* or *no*; whichever applies. Your answers are for our records only, and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health?.....YES NO

2. Has there been any change to your general health within the past year?.....YES NO

3. My last physical exam was on _____

4. Are you under the care of a physician?.....YES NO
If so, what is the condition being treated?_____

5. The name and address of my physician is_____
_____

6. Have you had a serious illness, operation, or been hospitalized in the past 5 yrs? YES NO
If so, what was the illness or problem?_____

7. Are you taking any medicine(s) including non-prescription medicine?.....YES NO
If so, what medicine(s) are you taking?_____

8. Do you have or have you had any of the following diseases or problems?

a) Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?.....YES NO

b) cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....YES NO

1. **Do you have chest pain upon exertion?.....YES NO**
2. **Are you ever short of breath after mild exercise or when lying down? Y N**
3. **Do your ankles swell?.....YES NO**
4. **Do you have inborn heart defects?.....YES NO**
5. **Do you have a cardiac pacemaker?.....YES NO**

c) Joint Replacement (location).....YES NO
d) Sinus trouble.....YES NO
e) Asthma or hay fever.....YES NO
f) Fainting spells or seizures..... YES NO
g) Persistent diarrhea or recent weight loss.....YES NO
h) Hepatitis, jaundice, or liver disease.....YES NO
i) Diabetes..... YES NO
j) AIDS or HIV infection.....YES NO
k) Thyroid problems.....YES NO
l) Respiratory problems, emphysema, bronchitis, etc..... YES NO
m) Arthritis or painful, swollen joints..... YES NO
n) Stomach ulcer or hyperacidity..... YES NO
o) Kidney trouble..... YES NO
p) Tuberculosis.....YES NO
q) Persistent cough or cough that produces blood.....YES NO
r) Persistent swollen glands in neck.....YES NO

s) Low blood pressure.....YES NO
t) Epilepsy or other neurological disease..... YES NO
u) Problems with mental health..... YES NO
v) Cancer..... YES NO
w) Problems of the immune system.....YES NO

9. Have you had abnormal bleeding?.....YES NO
a) Have you ever required a blood transfusion?..... YES NO
10. Do you have any blood disorder such as anemia?.....YES NO
11. Have you ever had any treatment for a tumor or growth?..... YES NO
12. Are you *allergic to* or have you had a reaction to:
a) Local anesthetics..... .....YES NO
b) Penicillin or other antibiotics ....YES NO
c) Sulfa drugs..... YES NO d)
Barbiturates, sedatives, or sleeping pills..... ....YES NO
e) Aspirin..... ..... YES NO
f) Iodine..... .....YES NO
g) Codeine or other narcotics ..... YES NO
h) Other..... YES NO

13. Have you had any serious trouble associated with previous dental treatment?.... YES NO
If so, please explain_____
_____

14. Do you have any disease, condition or problem not listed above that you think I should know about? _____ If so, please explain_____
_____

15. Are you wearing contact lenses? .....YES NO
16. Are you wearing removable dental appliances?..... YES NO
How old? _____

WOMEN

17. Are you pregnant ?.....YES NO
18. Do you have any problems with your menstrual period ?.....YES NO
19. Are you nursing ?.....YES NO
20. Are you taking birth control pills? .....YES NO

Chief Dental Complaint_____
_____
_____
_____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, including the initial visit, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I authorize the release of any information relating to my dental insurance claims. I understand that I am responsible for all costs of dental treatment not covered by my insurance company and that I will be billed for any co-insurance prior to any insurance payment.

I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party