CityTooth

Medical Arts (by IDS Tower)
825 Nicollet Mall, Suite 812
Minneapolis, MN 55402 USA
TELEPHONE: 612-338-2835
HOURS: M-Th, 8am – 4:30pm

CONFIDENTIAL HEALTH HISTORY

Patient name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question)

1 ◉ Yes ○ No Is your general health good?
If NO, explain: _____

2 ○ Yes ○ No Has there been a change in your health within the last year? If YES, explain:
_____

3 ○ Yes ○ No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain: _____

4 ○ Yes ○ No Are you being treated by a physician now? If YES, explain:
Date of last medical exam: _____ Reason for exam: _____

5 ○ Yes ○ No Have you had problems with prior dental treatment? If YES, explain:
_____

6 ○ Yes ○ No Are you in pain now? If YES, explain:
_____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please check all that apply)

☐Chest pain (angina)	☐Blood in stools	☐Frequent vomiting
☐Fainting spells	☐Diarrhea or constipation	☐Jaundice
☐Recent significant weight loss	☐Frequent urination	☐Dry mouth
☐Fever	☐Difficulty urinating	☐Excessive thirst
☐Night sweats	☐Ringing in ears	☐Difficulty swallowing
☐Persistent cough	☐Headaches	☐Swollen ankles
☐Coughing up blood	☐Dizziness	☐Joint pain or stiffness
☐Bleeding problems	☐Blurred vision	☐Shortness of breath
☐Blood in urine	☐Bruise easily	☐Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please check all that apply)

☐Heart disease	☐AIDS / HIV	☐Psychiatric care
☐Family history of heart disease	☐Surgeries	☐Osteoporosis
☐Heart attack	☐Hospitalization	☐Thyroid disease
☐Stomach problems, ulcers	☐Diabetes	☐Asthma
☐Xheart Defects	☐Family history of diabetes	☐Hepatitus
☐Heart murmurs	☐Tumors or cancer	☐Sexual transmitted disease
☐Rheumatic fever	☐Chemotherapy	☐Herpes
☐Skin disease	☐Radiation	☐Canker or cold sores
☐Hardening of arteries	☐Arthritis, rheumatism	☐Anemia
☐High blood pressure	☐Emphysema or other lung disease	☐Liver disease
☐Artificial joint	☐Kidney or bladder disease	☐Eye disease
☐Siezures	☐Stroke	☐Transplants
☐Cosmetic surgery	☐Eating disorder	☐Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please check all that apply)

☐Aspirin	☐Valium	☐Tetracycline
☐Darvon	☐Demerol	☐Vicodin
☐Codeine	☐Penicillin	☐Percodan
☐Local anesthetic (Novacaine, Xylocain)	☐Latex	☐Food
☐Nitrous oxide	☐Erythromycin	☐Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please check all that apply)

☐Recreational drugs	☐Tobacco in any form	☐Antibiotics
☐ Over-the-counter medicines	☐Alcohol	☐Supplements
☐Weight loss medications	☐ Bisphosphonate (Fosamax)	☐Aspirin

VI. WOMEN ONLY

○ Yes	○ No	Are you, or could you be, pregnant? If YES, what month?
○ Yes	○ No	Are you nursing?
○ Yes	○ No	Are you taking birth control pills?

VII. ALL PATIENTS

○ Yes	○ No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:
○ Yes	○ No	Have you ever been pre-medicated for dental treatment? If YES, why:
○ Yes	○ No	Have you ever taken Fen-phen? If YES, when:
○ **Yes**	○ **No**	**Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health history and / or medication. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% o the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group. Insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care for myself and/or my children. The information on this page and the and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____	
○Adult Patient ○Father (or Husband) ○Mother (or Wife) ○Guardian	
Date	State Driver's License #

FAIL/CANCELLATIONS

We trust that you will be here for the time you have reserved with us. If you fail or cancel without a 24 hour notice, a fee will be charged to your account.