MEDICAL HISTORY

The thoroughness of this medical history is for your safety and the safety of all others in our office. Your complete answers will assist us in treating you with consideration for all your special needs.

Physician_____ Phone _____

Address _____ Date of last visit _____

Other Physicians _____

Are you currently under the care of a physician? ___ Reason _____

Have you had any Serious Illnesses &/or have you been hospitalized?(please describe) _____

_____

Do you have or have you had: (please check box if the answer is "yes". leave blank if "no".

- ☐ Any current medical problem_____
- ☐ Any heart problems_____
- ☐ Circulatory problems_____
- ☐ Heart murmur_____
- ☐ Rheumatic Fever_____
- ☐ Heart attack_____
- ☐ Heart surgery_____
- ☐ Coronary Bypass_____
- ☐ Nervous problems_____
- ☐ Hypoglycemia_____
- ☐ Tonsils out_____
- ☐ Anemia_____
- ☐ Blood disease_____
- ☐ Hepatitis_____
- ☐ Venereal Diseases_____
- ☐ Liver Disease_____
- ☐ Glaucoma_____
- ☐ Hay Fever/Allergies_____
- ☐ Ulcers_____
- ☐ Blood transfusion_____
- ☐ Tumor/Cancer_____
- ☐ Chemotherapy_____
- ☐ Chronic Sinusitis_____
- ☐ Respiratory (Breathing) problems_____
- ☐ Have you been advised to take antibiotics before dental treatment?_____
- ☐ Recent physical exam_____
- ☐ Fainting, convulsions, epilepsy _____
- ☐ High Blood Pressure_____
- ☐ Low Blood Pressure_____
- ☐ Prolapsed Mitral Valve_____
- ☐ Angina (chest pains)_____
- ☐ Congenital heart Disease_____
- ☐ Pacemaker_____
- ☐ Prosthetic heart valve_____
- ☐ Diabetes_____
- ☐ Kidney disease_____
- ☐ Adenoids removed_____
- ☐ Excessive bleeding_____
- ☐ Asthma_____
- ☐ Positive HIV test_____
- ☐ Frequent or "Migraine" headaches_____
- ☐ Herpes_____
- ☐ Stroke_____
- ☐ Tuberculosis (TB)_____
- ☐ Arthritis_____
- ☐ Drug/Alcohol Addiction_____
- ☐ Thyroid Disease_____
- ☐ Prosthetic Joint replacement_____
- ☐ Radiation Therapy_____
- ☐ Women...Are you pregnant?_____

Are you allergic to or have you had any unusual reaction to:

- ☐ Penicillin
- ☐ "Novocaine"
- ☐ Codeine
- ☐ Erythromycin
- ☐ "Lidocaine"
- ☐ Aspirin
- ☐ Local Anesthetics
- ☐ Motrin (Advil, Nupren)
- ☐ Latex
- ☐ Others_____

Please list any medications you are now taking:

Name	Dose	Purpose

CONSENT

I hereby authorize Dr Gregg and staff to take X-rays, impressions, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of any dental and oral conditions. I authorize performance of any and all forms of treatment, medications and therapy that may be indicated. I understand that any dental treatment involves some form of risk.

Signature_____ Date _____ Staff _____

William Y. Gregg, DDS, FAGD, Inc
Daniel B. Balaze, DMD, FAGD
Personalized Dentistry

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(949) 770-7686

Name _____ Date _____
Last First Initial

Email: _____

Birthday_____ Social Security #_____ Driver's License #_____

Address _____ How Long?_____
Street City Zip

Cell Phone _____ Work Phone_____ Other Phone_____

Who may we thank for referring you to us? _____ Married? _____ Spouse Name _____

Your Employer _____ Occupation _____ Years _____

Employer Address _____ Phone _____

Spouse Employer _____ Occupation _____ Years _____

Employer Address _____ Phone _____

Name of relative not living with you _____ Phone _____

Address _____

Person financially responsible for this account? _____

Relationship to patient? _____ Signature _____

Address _____ Phone _____

Dental Insurance

Primary Insurance

Insured Name _____ Soc. Sec # _____ Birthdate _____

Insurance Company _____ Group # _____ Plan # _____

Address _____ Phone _____
Street City Zip

Employer Name _____ Phone _____

Effective Date _____ Deductible _____ Annual Limits _____

Limitations or Restrictions? _____

Secondary Insurance

Insured Name _____ Soc. Sec # _____ Birthdate _____

Insurance Company _____ Group # _____ Plan # _____

Address _____ Phone _____
Street City Zip

Employer Name _____ Phone _____

Effective Date _____ Deductible _____ Annual Limits _____

Limitations or Restrictions? _____