TRIANGLE FAMILY DENTISTRY

Patient Medical History Update

Patient Name: _____ **Date:** _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Gender: ☐ Male ☐ Female

1. Have you been seriously ill since your last office visit? ☐ Yes ☐ No
2. Have there been any changes in your medical history since your last office visits?

If yes, please explain: _____

_____

3. Is a medical doctor currently treating you? ☐ Yes ☐ No

If yes, please explain: _____

_____

4. Please provide your primary care physician's name and phone number:

_____

5. Please list any medications you are taking, prescription or over-the-counter:

_____

6. Are you allergic to, or have you had unusual reactions to any of the following?

Please check all that apply:

- ☐ Aspirin
- ☐ Iodine
- ☐ Metals
- ☐ Codeine
- ☐ Latex
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Other
- ☐ No Known Allergies

7. Please check the box if you have ever had or been told you have any of the following:

- ☐ Active Infection
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Depression
- ☐ Deviated Septum
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Frequent Headaches
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Hepatitis
- ☐ Herpes Hives
- ☐ Skin Rash
- ☐ Infective Endocarditis

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7 cont'd – Please check the box if you have ever had or been told you have any of the following:

- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Other
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease

Please explain: _____

8. Have you ever taken a bisphosphonate such as Fosamax, Actonel or Boniva? ☐ Yes ☐ No

QUALITY OF SLEEP:

9. Have you been told you snore occasionally? ☐ Yes ☐ No
10. Do you wish you slept better and had more energy? ☐ Yes ☐ No
11. Have you been prescribed or do you use a CPAP? ☐ Yes ☐ No
12. Do you feel tired throughout the day? ☐ Yes ☐ No

FOR WOMEN ONLY:

Women who take oral contraceptives (birth control pills) should take extra precautions when taking antibiotics because antibiotics can cause failure of birth control pills, which can result in pregnancy.

13. Are you pregnant or suspect that you may be pregnant? ☐ Yes ☐ No
14. Are you taking oral contraceptives (birth control pills)? ☐ Yes ☐ No
15. If you use other types of birth control medications that are not pills (such as Depo shots), please list:

_____

_____

16. My current dental goals are (please check all that apply):

- ☐ Whiter Teeth
- ☐ Pain Free
- ☐ Straighter Teeth
- ☐ Healthier Gums
- ☐ Replace Missing Teeth
- ☐ Full Dentures
- ☐ Cavity Free
- ☐ Better Breath
- ☐ Less Bleeding
- ☐ Decrease Sensitivity
- ☐ Partials
- ☐ Better Chewing
- ☐ Sedation Dentistry
- ☐ Stop Snoring

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge. I consent to the diagnostic procedures and dentistry necessary for proper dental care.

Signature X _____

TRIANGLE FAMILY DENTISTRY

Credit Card on File Agreement

Triangle Family Dentistry is implementing a credit card on file policy effective February 2023. Like many other dental and medical practices, we have adopted a similar policy. We kindly request our patient's guardian/guarantor provide a credit card which will be used to pay a balance. Co-pays are still due at the time of service. Your credit card information will be obtained and kept securely on file.

After your claim is paid, we will process your card on file for any balances less than $100.00 and send you a receipt for the charge. For balances over $100.00, you will receive an electronic statement and your prompt payment is expected within 7 days. You may call our office if you have question about your balance.

This "Card-on-File" policy simplifies payment for you, and it reduces paperwork, ultimately helping lower the cost of care. Our Guest Support team is always available to answer questions about the Credit Card on File payment method or any balances due.

By signing below, I authorize Triangle Family Dentistry to keep my signature and my credit card information securely on-file in my account. I authorize Triangle Family Dentistry to charge my credit card for any outstanding balances equal to or less than $100.00.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on Card (Print):_____

Cardholder Relationship to Patient: _____

Last Four Digits of Credit Card (CC) Number: _____ Exp.Date:_____

Please be advised, if the credit card on file differs from the CC info provided above, we will use CC on file.

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: _____

Patient Full Name (Print): _____ DOB: _____

Patient Full Name (Print): _____ DOB: _____

Credit Card Holder's Signature: _____ Date: _____