McMillen Dental

106 McMillen Drive

Newark, Ohio 43055
740-344-1171

Medical History **Patient Name:**_____

1. Are you having pain or discomfort at this time? **YES** **NO**
2. Have you been a patient in the hospital during the last two years? **YES** **NO**
3. Have you been under the care of a medical doctor during the past two years? **YES** **NO**
   Physician's Name_____
   Address_____ **Phone Number:** _____
4. Please list daily medications:_____

5. **Are you allergic or have you reacted adversely to any of the following medications?**
   - Aspirin Percodan Amoxicillin
   - Codeine Tylenol Vicodin
   - Demerol Valium Ibuprofen
   - Nitrous Oxide Keflex Sulfa
   - Erythromycin Penicillin
   - Tetracycline Local Anesthetic

6. Are you aware of being allergic/sensitive to any other medications or substances?
   _____

   If yes please list._____

7. **Circle which of the following you have had OR currently have:**
   - Angina Pectoris
   - High Blood Pressure
   - Heart Murmur
   - Congenital Heart Lesions
   - Scarlet Fever
   - Heart Pacemaker
   - Heart Surgery
   - Heart Disease
   - Heart Attack
   - Artificial Joints
   - Anemia
   - Emphysema
   - Cough
   - Tuberculosis
   - Asthma
   - Autism and/or ADHD
   - Allergies or Hives
   - Diabetes
   - Thyroid Disease
   - Radiation Treatment
   - Arthritis
   - Rheumatism
   - HIV
   - Hepatitis
   - Liver Disease
   - Yellow Jaundice
   - Blood Transfusion
   - Drug Addiction
   - Hemophilia
   - Mouth Sores
   - Epilepsy or Seizures
   - Acid Reflux
   - Bruise Easily
   - Sickle Cell Disease
   - Ulcers
   - Chemotherapy
   - Cancer
   - Sleep Apnea
   - MVP
   - Stroke
   - Downs Syndrome
   - Are you Pregnant?
     yes **no**
     If yes due date_____
   - Sinus Trouble
   - Fainting or Dizzy Spells
   - Parkinson's Disease

8. Do you have a Latex Allergy? **YES** **NO**
9. Have you been told by your doctor you need Premed (antibiotic) before dental treatment? **YES** **NO**

10. Have you had any surgeries that have required you to have rods, pins or plates placed? **YES NO**
11. List any surgeries:_____
12. Do you have any disease, condition, or problem not listed? **YES NO**
13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? **YES NO**
14. Do you smoke or use smokeless tobacco and if so how much? **YES _____ NO**

14: Would you like to share with us your previous dentist in case we may need to obtain previous dental records (i.e. dental x-rays) _____.

15: Consent: The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms treatment, medication, and therapy that may be indicated in connection with (name of patient)_____ _____and further authorize and consent that the doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. **I understand that it is my responsibility to notify the doctor of any changes in my health or address history.**

Parent or Guardian of minor: _____ Date: _____

Patient Signature:_____ Date:_____

McMillen Dental Financial Agreement

I authorize the Insurance Manager of McMillen Dental to collect and apply for the account within McMillen Dental. I also authorize the Insurance Manager of McMillen Dental to collect any of the insurance amounts for the family under any contract of insurance for services performed at the office. I understand that my dental insurance is a contract between myself and the insurance carrier and not between the insurance carrier and the dentist and I am responsible for all dental fees. This authorization will remain in force and effect until the office of McMillen Dental receives written notice. I also understand that it is my responsibility to notify McMillen Dental of any changes in my dental insurance carrier.

All financial arrangements are made before scheduling any treatment. I understand that the portion of treatment for myself or dependents that is not covered by my insurance is due and payable at each visit unless other financial arrangements have been made. **I also assign all insurance benefits to the Doctors of McMillen Dental.** I understand the person who brings the minor child is financially responsible. There will be a thirty dollar ($30.00) additional charge for any returned checks that are written to the Owner or the office of McMillen Dental. A missed appointment is a loss to everyone, IF you are unable to keep an appointment; we ask that you kindly provide a minimum of two business day notice and that you contact the office during our normal business hours to change an appointment. This courtesy on your part will allow us to give your appointment to another patient who needs to see the Doctor.

In the event of default I (we) promise to pay all legal cost on the indebtedness, together with such collection costs and reasonable fees accrued as may be required in effect collection of your account.

(Acknowledges and Accepted)

_____

(Sign) (Date)