MEDICAL HISTORY

Physician's Name _____ Date of last visit_____

Phone (_____) _____ Pharmacy _____ Phone (_____)_____

Please check ( ) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Have you ever had or been		
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Diagnosed with:		
Circulatory Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Artificial Joints, Screws,		
Cough, persistent or bloody	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	Pins, etc.	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Bleeding abnormally, with		
Emphysema	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	extractions or surgery	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Blood disease	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Special Diet/ Weight Loss	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hernia Repair	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Hepatitis Type _____	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medication	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Are you allergic to:

Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Bananas	☐ Yes	☐ No
Other _____		

Please PRINT all medications now taking: _____

_____

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and A / or my dependant (s) have insurance coverage with _____ and assign directly to
Name of Insurance Company
Dr. Nestlerode all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.

The above-named doctor may use my health care information any may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits payable for related services.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. Nestlerode to use and / or disclose my Protected Health Information (PHI) related to any applicable circumstance.

In understand that one the information is released it may be re-disclosed by the recipient and may no longer be protected by the federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the HPI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization. I have received a copy of PVDG's "Patient Notice Privacy Practices" that outlines how my confidential information will be used, disclosed, and protected.

_____ _____
Signature of Patient, guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, guardian or Personal Representative_____ Relationship to Patient_____