# Advanced Family Dental Care Medical History Update

**Dr. Dustin Wilde D.M.D.**

**Name:**_____ **Cell Phone:**_____

**Mailing Address:**_____**Zip Code:**_____

**Any changes to insurance? Yes/No. If yes, update:** _____**Email:** _____

**Are you interested in learning more about:**

Reducing snoring through Solea Laser Therapy? **Yes/No**

Cosmetic Botox? **Yes/No**

Eliminating tongue ties in infants & adults using the Solea Laser? **Yes/No**

Reducing grinding/clenching through Botox injections? **Yes/No**

Straightening teeth with Sure Smile clear aligners? **Yes/No**

**Medical History**

Name/Telephone number of Physician_____

Are you currently under the care of a Physician?_____

Have you had major surgery in the past 3 years?_____

Are you on any blood thinners? **Yes/No** If female: Are you pregnant? **Yes/No** Nursing? **Yes/No** Birth Control? **Yes/No**

Are you on any bone density meds? **Yes/No**

**Please check if you have any of the following:**

- □ AIDS/HIV
- □ Anemia
- □ Angina/Chest Pain
- □ Arthritis
- □ Artificial Heart Valve
- □ Artificial Joints
- □ Asthma
- □ Bruise/Bleed Easily
- □ Cancer _____
- □ Chemotherapy
- □ Cold Sores/Herpes
- □ Congenital Heart Lesion
- □ COPD
- □ Diabetes
- □ Dry Mouth
- □ Emphysema/ Bronchitis
- □ Epilepsy/Seizures
- □ Fainting/Dizziness
- □ Fibromyalgia
- □ Heart Disease / Murmur/Surgery
- □ Hepatitis A/B/C
- □ High Blood Pressure
- □ Kidney Problems
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Nervous/Anxious
- □ Organ Transplant
- □ Pacemaker
- □ Persistent Cough
- □ Pneumonia
- □ Radiation Therapy
- □ Rheumatic Fever
- □ Sinus Problems
- □ Stroke
- □ Thyroid Disease
- □ Tobacco Use
- □ Tuberculosis/PPD
- □ Osteoporosis

**Do you have any other condition, disease, or problem not previously listed? _____**

**Drug Allergies:**

- □ Aspirin/Coumadin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Latex
- □ Penicillin
- □ Tetracycline
- □ Other_____

**Please list all medications you are taking, including over the counter drugs and herbs:**

Medication: Dosage: Times/Day

_____

_____

**Account Responsibility**

I understand that Advanced Family Dental Care will assist me in billing my primary, and secondary insurances. I also understand that regardless of what my insurance pays, I am responsible for the bill for all dental treatment. If my insurance doesn't pay within 90 days, I also understand that the entire account balance will be due, and payable, by me. Furthermore, I have been notified that Advanced Family Dental Care is not an agent, or broker, for any dental insurance that I may have. The insurance company is a separate entity that this dental office will bill for me, but I understand that Advanced Family Dental Care cannot guarantee coverage or benefits for the treatment that I may receive. I hereby authorize that insurance payments are to be paid directly to Advanced Family Dental Care. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations rendered, to my insurance company. I also understand that I am responsible for any fees incurred if this account is sent to a collection agency.

**Emergency Contact**:_____ **Phone number**:_____

**Do you authorize us to communicate and discuss treatment / account information with another individual, such as spouse or relative?** Name_____ Relationship to patient_____

**Signature**_____ **Date:**_____