



Max Arocha D.M.D., P.A.
General, Cosmetic & Implant Dentistry

MEDICAL HISTORY
Patient Acquaintance Form (please print)

Patient's Name _____
Last First Middle

Address _____
Street Apt. City State Zip Code

How long at this address? _____ Driver's License# _____

Home Phone _____ Work Phone _____ Fax _____

Pager/Beeper _____ E-Mail _____ Cell Phone _____

Sex _____ (M/F) Marital Status _____ SS# _____ Birth Date _____ / _____ / _____

Insurance: Yes/No Insurance Company _____ SS# of Subscriber _____

Employer _____ Occupation _____ # of yrs employed _____

How were you referred to our office? _____

RESPONSIBLE PARTY

Name _____
Last First Middle

Address _____
Street Apt. City State Zip Code

How long at this address? _____ Driver's License# _____

Home Phone _____ Work Phone _____ Fax _____

Pager/Beeper _____ E-Mail _____ Cell Phone _____

Sex _____ (M/F) Marital Status _____ SS# _____ Birth Date _____ / _____ / _____

Employer _____ Occupation _____ # of yrs employed _____

REPRESENTATIONS

1. I understand that the information that I have given (including my medical history on page 2) is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
2. I authorize this office to verify my and my spouse's credit status prior to extending credit for the treatment and at the discretion of this office. To use the services of one or more credit reporting services.
3. If this office accepts insurance, I authorize payment directly to this office of any insurance benefits otherwise payable to me and I assign any and all benefits to the office, and I for paying any co-payment and deductibles that my insurance does not cover.
4. If collection efforts are undertaken due to my failure to pay any and all fees to this office. I agree to be responsible for any attorney's fees and costs incurred in connection with such collection efforts. I also understand that I will be charged interest at the rate of 1.5% per month on any outstanding balance (or the maximum allowed by law).
5. I consent to and authorize treatment recommended by the dental staff.

Patient signature (parent's signature if minor or guardian)

Date

MEDICAL HISTORY

Does your medical history include any of the following:

Yes	No	
_____	_____	1. Are you in good health?
_____	_____	2. Has your health changed within the past year? _____
_____	_____	3. My physician's name and phone number is _____
_____	_____	4. Have you ever had any serious illness or operations?
_____	_____	5. Damaged or artificial heart valves/rheumatic fever?
_____	_____	6. Heart or cardiovascular disease (heart attack, angina)?
_____	_____	7. High or low blood pressure?
_____	_____	8. Abnormal bleeding?
_____	_____	9. Stroke?
_____	_____	10. Circulatory Problems?
_____	_____	11. Allergies to medicines or drugs? If yes, what? _____
_____	_____	12. Chest pains?
_____	_____	13. Sinus trouble?
_____	_____	14. Asthma or hay fever?
_____	_____	15. Fainting spells or seizures
_____	_____	16. Diabetes? If yes, what was your last blood sugar level? _____ When was it last taken? _____
_____	_____	17. Hepatitis, jaundice or liver disease?
_____	_____	18. Aids or HIV Infection?
_____	_____	19. Thyroid Problems?
_____	_____	20. Respiratory problems, emphysema or bronchitis?
_____	_____	21. Kidney trouble?
_____	_____	22. Tuberculosis?
_____	_____	23. Sexually transmitted disease? Please explain _____
_____	_____	24. Epilepsy or other neurological disease?
_____	_____	25. Problems with mental health or nervous problems?
_____	_____	26. Cancer? _____
_____	_____	27. Radiation treatments for cancer, tumors or growths?
_____	_____	28. Problems with previous dental treatment?
_____	_____	29. Allergic to penicillin, erythromycin or codeine?
_____	_____	30. Pregnant or nursing?
_____	_____	31. Are you taking birth control pills?
_____	_____	32. Do you have any other health concerns not mentioned? Explain _____
_____	_____	33. List any drugs you are presently taking _____
_____	_____	34. Pharmacy name and telephone number _____

PATIENT CONTRACT INFORMATION

In case of emergency, please notify _____
Name Telephone Number

We will confirm your appointment between 8:30 AM and 4:00 PM the day before scheduled. At what phone number will be able to contact you during these hours? _____

If you cannot be reached by telephone during these hours, how and where can we contact you to confirm your appointment? _____

DOCTOR'S NOTES

