HEALTH HISTORY

Name_____ Insurance Changes: yes or no

Address:_____DOB_____ Cell:_____

City:_____State____zip_____ Home: _____

Email address:_____ Social Security#_____

Answer all questions by circling yes or no. If you do not understand a question, ask the office staff. All information is confidential.

Are you currently in good health?..... Yes No
Are you currently under a physician's care?..... Yes No
If so, please explain_____
Are you taking any medications (prescription or nonprescription)?..... Yes No
If so, please _____
_____
Are you allergic to any medication (penicillin, local anesthetics, etc)? ..... Yes No
If so, please list_____
Do you use tobacco products ?..... Yes No
If so, what type?_____How often?_____
Do you have a history of heart trouble (congenital problems, angina, etc.?..... Yes No
If so, please explain_____
Do you bleed excessively from cuts or surgery?..... Yes No
For Women, are you pregnant?..... Yes No

Would you like to use Nitrous Oxide during your treatment?_____ Yes No
A 45.00 fee will be charged, NOT covered by most insurance.

Do you have or have you ever been diagnosed with the following?

Acid Reflux.....	Yes	No	Cancer.....	Yes	No
Heart Murmur or Mitral Valve Prolapse...	Yes	No	Radiation Treatment.....	Yes	No
High or low Blood pressure (circle one)...	Yes	No	Epilepsy.....	Yes	No
Artificial joints or heart valve	Yes	No	Liver problems (Hepatitis A,B,C)...	Yes	No
Breathing Difficulties or Asthma.....	Yes	No	HTLV/AIDS.....	Yes	No
Diabetes.....	Yes	No	TB.....	Yes	No
Thyroid problems.....	Yes	No	Kidney Problems.....	Yes	No
Psychiatric Problems.....	Yes	No	Fainting Spells.....	Yes	No

Are there any conditions not listed above that we should know about?.....
If so, please explain_____

The above is correct to the best of my knowledge. Please report any changes in your health history before any future appointments.

Signature of patient or guardian_____Date_____

Reviewed By_____Date_____

Camden Dental Care 206 Arnow Dr. St. Marys GA 31558 912-882-2005

Authorization for Release of Information

I,_____, give permission for_____to share the information about me ONLY to any referring doctor's office or person's listed below.

_____

_____

How long this permission last.

This permission to share my information is good until_____.

If I do not list date, this permission will last for one year from date it is signed.

I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to Camden Dental Care, and send it or bring it into the office.

I understand that if I choose not to give or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

Signature

_____ Date_____

Print name_____

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out form:_____

Signature of the person filing out this form:_____

Describe how this person has legal authority for this individual:_____