ROBERT ROGERS, DDS
Family & Implant Dentistry

980 Lee-Ann Drive • Concord, NC 28025

MEDICAL HISTORY

HAVE YOU HAD OR DO YOU CURRENTLY HAVE	YES	NO	NOTES
Rheumatic fever?			
Damaged heart valves / mitral valve prolapse?			
Heart murmer?			
High blood pressure?			
Low blood pressure?			
Chest pain / angina?			
Heart attack(s)?			
Irregular heart beat?			
Cardiac pacemaker?			
Heart surgery?			
Pneumonia, bronchitis, chronic cough?			
Ashtma?			
Hay fever / sinus problems?			
Snoring / sleep apnea?			
Difficult breathing / other lung trouble?			
Tuberculosis?			
Emphysema?			
Do you smoke? If so, number of packs a day ____			
Do you use chewing tobacco?			
Blood transfusion?			
Blood disorder such as anemia?			
Bruise easily?			
Bleeding tendency / abnormal bleed?			
Hepatitis, jaundice, or liver disease?			
Gallbladder trouble?			
Fainting spells?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE	YES	NO	NOTES
Convulsions / epilepsy?			
Stroke?			
Thyroid trouble?			
Diabetes?			
Low blood sugar?			
Kidney trouble?			
High cholesterol?			
Are you on dialysis?			
Swollen ankles / arthritis / joint disease?			
Osteoporosis / osteopenia?			
Stomach ulcers / acid reflux?			
Contagious diseases?			
Sexually transmitted diseases?			
Problems with immune system? Possibly from medication / surgery, etc.?			
Delay in healing?			
A tumor or growth?			
Cancer / radiation therapy / chemotherapy?			
Chronic fatigue / night sweats?			
Are you on a diet?			
A history of alcohol abuse? A history of drug abuse?			
Mental health problems / anxiety / depression?			
A removable dental appliance?			
Pain or clicking of jaws when eating?			
Dry mouth			
Sjogren's Syndrome			

ARE YOU NOW TAKING:	YES	NO	NOTES
Any kind of medication, drug, pills?			
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
Have you ever taken diet pills?			
Any natural product, herbal supplement or homeopathic remedy?			
Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia in the past 12 years?			

Tranquilizers, sleeping pills, anti-depressants, and / or narcotics on a regular basis? If so, please list:

Please list any medications you are currently taking:

Medication	Dosage	Frequency

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

FOR WOMEN ONLY	YES	NO	NOTES
Is there a possiblity of pregnancy?			
Expected delivery date?			
Are you nursing?			
Are you taking birth control pills?			

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynocologist for assistance regarding other methods of birth control.*

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
Local anesthetic (numbing meds)?			
Penecillin?			
Other antibiotics?			
Sulfa drugs?			
Sodium pentothal / Valium / other tranquilizers?			
Aspirin?			
Amoxicillin?			
Codeine or other narcotics?			
Other medications?			
Latex?			
Soy?			
Eggs / yolk?			
Sulfites?			
Do you have any known allergies?			
Please list any allergies other than drug allergies.			
Anesthesia problems?			

HEALTH HISTORY

REASON FOR TODAY'S OFFICE VISIT? _____

		YES	NO
Are you under the care of a physician?	Date of last visit _____		
Have you had any illness, operation, or been hospitalized?			
Do you have a prosthetic joint / implant?	If so, describe where _____		
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			

I certify that I have read and I understand the questions asked on this form. I acknowledge that my questions, if any, about the inquiries set forth on this form have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and / or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my dental surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and / or insurance carriers. I permit message to be left on my phone conerning my appointment.

X _____ X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Witness** **Doctor** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**