

Patient Name _____

Date of Birth _____

MEDICAL HISTORY FORM

Medical doctor's name _____

Are you under a doctor's care now? Why? _____ Yes No

Have you been hospitalized during the past two years? Why? _____ Yes No

Are you taking any medications, pills, or drugs? _____ Yes No

Are you allergic to any medications or substances? What? _____ Yes No

Do you require medications for dental or other treatment? _____ Yes No

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | | |
|------------------------|-----------------------|------------------|-------------------------|
| Heart Trouble | Chest Pain | Scarlet Fever | Cancer |
| High Blood Pressure | Shortness of Breath | Hay Fever | Herpes |
| Heart Murmur | Fainting or Dizziness | Emphysema | Ulcers |
| Rheumatic Fever | Hepatitis A (infect.) | Frequent Cough | Cold Sores |
| Asthma | | Drug Addiction | Congenital Heart Lesion |
| Hepatitis B (serum) | Lung Disease | Glaucoma | Artificial Heart Valve |
| Excessive Thirst | Tuberculosis | Rheumatism | Heart Pacemaker |
| Artificial Joints/Hips | Liver Disease | Arthritis/Gout | Heart Surgery |
| Kidney Trouble | Diabetes | Bruise Easily | Blood Disease |
| Yellow Jaundice | Thyroid Disease | Hemophilia | Anemia |
| Parathyroid Disease | Allergies | Nervousness | X-ray or Cobalt Tmt. |
| Blood Transfusion | Hypoglycemia | Veneral Diseases | Prolonged Bleeding |
| Pain in Jaw Joints | Fever Blisters | Contact Lenses | Epilepsy Seizures |
| Psychiatric Care | Sickle Cell | Chemotherapy | |

Have you ever had any other serious illness not circled above? _____ Yes No

Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? _____

Please advise us of any change in your medical history. This medical history will be updated annually.
I have provided this medical history. It is complete and accurate to the best of my knowledge.

X _____
Patient/Parent Signature

Reviewed by: _____
Doctor

Date _____

Updates (date & initials) _____ / _____ / _____

AUTHORIZATION

I hereby authorize Joseph A. Catania, D.D.S. to perform such diagnostic and therapeutic procedures as may be necessary for proper orthodontic care. I understand that I am responsible for all costs of dental treatment. As related to my insurance coverage for orthodontic care, I authorize release of any information relating to my claim. I hereby authorize payment directly to Joseph A. Catania, D.D.S. of the group insurance benefits otherwise payable to me.

SIGNATURE OF RESPONSIBLE PARTY

X _____
 Adult Patient Father (or Husband) Mother (or Wife) Guardian

Date _____