MEDICAL HISTORY ©

Dr. Allyson Hurley Phone: (973) 701-7777 FAX (973) 701-7775

PHYSICIAN'S NAME _____ ADDRESS_____

PHYSICIAN'S PHONE NUMBER _____ DATE OF LAST PHYSICAL_____

MANY DISEASES ARE FIRST DIAGNOSED IN THE MOUTH SO WE NEED TO KNOW IF YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

- ☐ Aids/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (hip or knee)
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Back Problems
- ☐ Bleeding Abnormally from Cut or Extraction
- ☐ Blood Disease
- ☐ Breathing Difficulties
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ Circulatory Problems
- ☐ Claustrophobia
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes
- ☐ Eating Disorder: Bulimia, Anorexia
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fainting or Dizziness
- ☐ Gastric Acid Reflux (GERD)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Hormone Replacement Therapy
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low/High Blood Pressure
- ☐ Lyme Disease
- ☐ Mitral Valve Prolapse
- ☐ Neurological Problems
- ☐ Pacemaker
- ☐ Panic Disorder
- ☐ Parkinson's Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Systemic Lupus
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor on Head or Neck
- ☐ Weight Loss, Unexplained

☐ Recent Surgery? Date_____

MEDICATIONS

List any medications you are currently taking, current treatment, and correlating diagnosis. Please include birth control pills, herbal supplements, and aspirin. (Please be advised that antibiotics can negate the effects of birth control pills.) _____

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ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Food
- ☐ Sulfa
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Seasonal

Other:_____

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APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 48 hours. Once an appointment has been made please remember this time has been reserved for you.
INSURANCE: To avoid any misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that you are personally responsible for payment of fees at time of service. To help you obtain your dental benefits you will be given a form for submission to your insurance company.

AUTHORIZATION FOR PHOTOGRAPHY

I, _____, hereby consent that photographs and/or video pictures may be taken of me by Allyson K. Hurley, DDS, or any authorized agent of Dr. Hurley's, for any of the following purposes:

1. For inclusion in my dental records, and to communicate with the dental lab.
2. For the purpose of illustration, publication in dental journals, book, or for other dental purpose deemed appropriate by my dentist.
3. Law enforcement request
4. Publicity ad compaigns
5. Website

SIGNATURE _____ DATE_____

Parent or guardian if patient is a minor