Medical History

Gentle Family Dentistry
861 Lafayette Rd Hampton NH 03842
603-926-4575

Date_____

Name_____**Address**_____
Last First Middle Number & Street

_____
City State Zip Code Home Phone Business Phone

Date of Birth_____**Sex**____**Height**____**Weight**_____**E-Mail**_____

Social Security No._____**Single**_____**Married**_____**Name of Spouse**_____

Closest Relative_____**Phone**_____

If you are completing this form for another person, what is your relationship to that person? _____

Referred By: _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1) **Are you in good health**.....**YES NO**
2) **Has there been any change in your general health within the past year?** .....**YES NO**
3) **My last physical examination was on** _____
4) **Are you under the care of a physician?** .....**YES NO**
   a) **If so, what was the illness or operation?** _____
5) **The name and address of my physician is** _____
   _____

6) **Have you had any serious illness or operation?** .....**YES NO**
7) **Have you been hospitalized or had a serious illness within the past five years?** .....**YES NO**
   a) **If so, what was the problem?** _____
8) **Do you have or have you had any of the following diseases or problems?** .....**YES NO**
   a) **Damaged heart Valves or artificial heart valves** .....**YES NO**
   b) **Congenital heart lesions** .....**YES NO**
   c) **Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, High blood pressure, arteriosclerosis, stroke)**
      (1) **Do you have pain in chest upon exertion?** .....**YES NO**
      (2) **Are you ever short of breath after mild exercise?** .....**YES NO**
      (3) **Do your ankles swell?** .....**YES NO**
      (4) **Do you get short of breath when you lie down, or do you require extra pillows when you sleep?** .....**YES NO**
      (5) **Do you have a cardiac pacemaker?** .....**YES NO**
   d) **Allergy** .....**YES NO**
   e) **Sinus Trouble** .....**YES NO**
   f) **Asthma or hay fever** .....**YES NO**
   g) **Hives or skin rash** .....**YES NO**
   h) **Fainting spells or seizures** .....**YES NO**
   i) **Diabetes**.....**YES NO**
      (1) **Do you have to urinate (pass water) more than six times a day?** .....**YES NO**
      (2) **Are you thirsty much of the time?** .....**YES NO**
      (3) **Does your mouth frequently become dry?** .....**YES NO**
   j) **Hepatitis, jaundice or liver disease** .....**YES NO**
   k) **Arthritis** .....**YES NO**
   l) **Inflammatory rheumatism (painful swollen joints)** .....**YES NO**
   m) **Stomach Ulcers** .....**YES NO**
   n) **Kidney trouble** .....**YES NO**
   o) **Tuberculosis** .....**YES NO**
   p) **Do you have a persistent cough or cough up blood?** .....**YES NO**
   q) **Low blood pressure** .....**YES NO**

r) Venereal disease .....YES NO
s) AIDS or HIV disease .....YES NO

9) Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? .....YES NO
   a) Do you bruise easily? .....YES NO
   b) Have you ever required a blood transfusion? .....YES NO

If so, explain the circumstances_____

_____

10) Do you have any blood disorder such as anemia? .....YES NO
11) Have you had surgery or x-ray for a tumor, growth, or other condition of your head or neck? .....YES NO
12) Are you taking any drug or medicine? .....YES NO
    If so, what? _____
13) Are you taking any of the following:
    a) Antibiotics or sulfa drugs? .....YES NO
    b) Anticoagulants (blood thinners)? .....YES NO
    c) Medicine for high blood pressure? .....YES NO
    d) Cortisone (steroids)? .....YES NO
    e) Tranquilizers? .....YES NO
    f) Antihistamines? .....YES NO
    g) Aspirin? .....YES NO
    h) Insulin, tolbutamide (orinase) or similar drug? .....YES NO
    i) Digitalis or drugs for heart trouble? .....YES NO
    j) Nitroglycerin? .....YES NO
    k) Oral contraceptives or other hormonal therapy? .....YES NO
    l) Other? .....YES NO
14) Are you allergic or have you reacted adversely to:
    a) Local anesthetics? .....YES NO
    b) Penicillin or other antibiotics? .....YES NO
    c) Sulfa drugs? .....YES NO
    d) Barbiturates, sedatives, or sleeping pills? .....YES NO
    e) Aspirin? .....YES NO
    f) Iodine? .....YES NO
    g) Codeine or other narcotics? .....YES NO
    h) Other? .....YES NO
15) Have you had any serious trouble associated with any previous dental treatment? .....YES NO
    If so, explain _____
16) Do you have any disease, condition, or problem not listed above that you think I should know about? .....YES NO
    If so, explain _____
17) Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation?
18) Are you wearing contact lenses? .....YES NO
19) Have you had any joint replacements: hip, knee or shoulder? .....YES . NO
20) Have you had any fusions of your neck or back? .....YES NO
21) Do you smoke? .....YES NO
    If so, how many packs per day: _____

WOMEN

22) Are you pregnant? .....YES NO
23) Do you have any problems associated with your menstrual cycle? .....YES NO
24) Are you nursing? .....YES NO

CHIEF DENTAL COMPLAINT:

_____ _____
SIGNATURE OF PATIENT

Dr. Bei Li
Financial Policy

861 Lafayette Rd., Unit 1
Hampton, NH 03842

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your questions and/or assist you in any way we can.

All payment is due at the time treatment is rendered. We accept cash, checks, credit cards, and outside financing is available.

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.

We are happy to offer a 3% discount for all treatment over $2,000 that is paid in full prior to treatment.

An 18% annual percentage rate will be billed to outstanding accounts if not paid in full in the first 30 days. If you do not show for an appointment or give proper 24-hour notice to cancel your appointment you will be charged 75.00/hygiene and $150/doctor fees for the broken appointment.

I, _____, understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. I have read all of the above and agree to all terms.

Patient/Parent Signature: _____

Date:_____

Dr. Bei Li D.D.S

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)