Time 6:49 AM

Lexington Dental Center

Date 7/7/2020

Medical Hipaa Financial

Patient Name: Birth Date: Date Created:

Who is your physician and are you under their care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Steroid Medicine	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No
Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge the questions on this form have been accurately answered. I acknowledge the receipt of the Notice of Privacy Practices and authorize the release of identifying health information for the purposes of treatment and payment as outlined in the Notice of Privacy Practices. I understand that I am financially responsible for charges billed to my account. This responsibility exists regardless of my insurance coverage. I also understand that while Lexington Dental Center will make every effort to obtain compensation from my insurance, it is my responsibility to be aware of my policy's benefits and exclusions.

Signature of Patient, Parent or Guardian:

X

Date:_____