Time 2:19 PM | Lexington Dental Center | Date 1/11/2023

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:_____