MEDICAL HISTORY

Change of address or phone number YES/NO Date_____
We would like to take the opportunity to bring your medical history up to date. Email_____
Name_____ Date of Birth_____
Male/Female_____Home Phone_____Cell Phone_____Work Phone_____
Address_____City_____State_____Zip_____
Date of last medical exam_____Reason_____
Have you been under the care of a doctor anytime during the last three years?_____
Name of usual physician_____Name of dental insurance co._____
Other physical conditions_____

Have you ever had any of the following? Please check those that apply:

□ Please List Allergies
_____
_____
□ Codeine Allergy
□ Penicillin Allergy
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Heart Murmur
□ Chest Pain/Pressure
□ Hepatitis Type:___
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Nervous Disorders
□ Pacemaker
□ Pregnancies
Due Date:_____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Tobacco Use
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Tumors
□ Ulcers
□ Venereal Disease
□ HIV/AIDS
□ Sickle Cell Trait
□ Thyroid Disease
□ Have you ever taken Bisphosphonate (Fosamax, Boniva, Actonel)
□ **LIST CURRENT MEDS:**
_____
_____
_____
_____
_____
_____

I have been given access to this office's Notice of Privacy Practices and the Financial Guidelines.
Signed_____

Signature on File Authorization
I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me, directly to the below named dentist or dental entity.

Guy G. Levy, D.D.S., PC
1320 Kiln Creek Parkway, Suite L Yorktown, VA 23693

_____Date_____
Patient Signature
_____Date_____

_____Date_____

_____Date_____