Fielfer Murga, DDS

DENTAL Wellness

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PATIENT INFORMATION (CONFIDENTAL)

Cellular ( )______________________________
Home Phone ( )_________________________

Name____ **Birthdate** ___________________________________

Address____

City_______________________________________ ____ **State** ______________________________ **Zip Code** ______________________

Sex M ☐ **F** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐

Social Security Number____ **Email**____

Person to Contact in Case of Emergency ____ **Phone** ___________________________

PATIENT MEDICAL HISTORY

Physician ____ Date of Last Exam___________________________

___ Heart Disease
___ High Blood Pressure
____Stroke
____Respiratory Problems
____Radiation Therapy
____Cardiac Pacemaker
____Recent Weight Loss
____ Asthma
____ Diabetes
___ Epilepsy/Seizures
___ Thyroid Problem
____Hepatitis
____ Cancer
____Glaucoma
____ Arthritis
____ Allergies
____ Alergias Generales
____ Anemia
___ Liver Disease
___ Angina
____Rheumatic Fever
____Sinus
____VIH/Sida
____Tuberculosis
____ Low Blood Pressure
____ Ulcers
____ Other

Are you allergic to any medications? YES ☐ NO ☐

If you answer is affirmative, please specify?____

Are you taking any medication(s) including non-prescription medicine? YES ☐ NO ☐

If yes, what medication(s) are you taking? ____

Are you under medical treatment now? YES ☐ NO ☐

(WOMEN ONLY) Are you pregnant or think you may be pregnant? YES ☐ NO ☐
Are you nursing? YES ☐ NO ☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such denial care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my denial insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date ______________________________________ Signature ____