MayFair Dental Associates, P.C.

Linda Goodman, D.D.S. **Mark Isler, D.D.S., M.S.**

28200 Orchard Lake Rd Ste 100 Farmington Hills, MI 48334 **248-851-3030**

Medical History and Consent

Date _____

First Name_____ Last Name_____ Middle initial____ Preferred name_____
Sex M ○ F ○ Birth Day_____ Age_____
Address_____ City _____ State_____ Zip_____
Home Phone _____ Cell/Mobile_____ Work_____ Ext_____
Email _____ Preferred method of Contact Call ○ Text ○ Email ○
Social Security Number_____ Drivers License Number _____ state_____
Marital Status: Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Spouses Name _____
Occupation _____ or if Student: Part Time ○ Full Time ○ Name of School _____
Referred to us by _____ Emergency Contact _____
Number_____ Relation to patient_____
If Over 18 years of age- I consent that MayFair Dental Associates may talk to my parents/ spouse regarding my treatment and account
Yes ○ No ○ Please List Whom we may share information with : _____

Primary Dental Insurance Information

PolicyHolder _____ Relationship to PolicyHolder Self ○ Spouse ○ Child ○ Other ○
PolicyHolder Social Security Number_____ PolicyHolder Birthday_____
Employer_____ Employers Address_____
Insurance Company _____ Member ID _____ Group #_____

Secondary Dental Insurance Information

PolicyHolder_____ Relationship to PolicyHolder Self ○ Spouse ○ Child ○ Other ○
PolicyHolder Social Security Number_____ PolicyHolder Birthday_____
Employer_____ Employers Address_____
Insurance Company _____ Member ID _____ Group #_____

Medical Insurance Information

PolicyHolder_____ Relationship to PolicyHolder Self ○ Spouse ○ Child ○ Other ○
PolicyHolder Social Security Number_____ PolicyHolder Birthday_____
Employer_____ Employers Address_____
Insurance Company _____ Member ID _____ Group #_____

List any medications you are taking:

Medication Dosage/Freq Prescriber Reason

1. _____
2. _____
3. _____
4. _____
5. _____

List any surgeries or hospitalization you have had:

Date (year) Surgery Surgeon Reason

_____
_____
_____
_____
_____

List and detail any medical conditions or history:

_____
_____
_____

Primary Physician's Name: _____ Physicians phone # _____

Are you under the care of other physicians? If so, please list:

Physician Phone # Reason

_____
_____

I agree that my physician(s) may be contacted to complete details of my medical history if required.
Please Initial_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____
_____
_____
_____
_____

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (Ringing)	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

General

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip replacement	Y	N
Liver Problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficult Chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Tooth Pain	Y	N
Wisdom teeth extraction	Y	N
Removable teeth?	Y	N
Take any antibiotics for dental procedures?	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorder	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
How Often?_____		
Do you snore?	Y	N
Difficulty Sleeping/Insomnia?	Y	N

Social History

Do you smoke?	Y	N
__ Packs a day		
Do you use smokeless tobacco?	Y	N
Do you drink alcoholic beverages?	Y	N
____ Drinks per day/week/month		
History of substance abuse?	Y	N
Use of recreational drugs?	Y	N

Women Only

Pregnant /Nursing	Y	N
Birth Control	Y	N

Health History Update Has there been any changes in your health or medications since your last update?

Date _____ N Y Comments _____ Signature_____

Date _____ N Y Comments _____ Signature_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned herby authorize MayFair Dental Associates, PC to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize MayFair Dental Associates, PC to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that MayFair Dental Associates, PC choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by MayFair Dental Associates, PC . To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of service provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for the services rendered not covered by my dental or medical insurance (if any). I Further consent to and agree to pay 1 1/2 finance charge (18%) annually that will be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize MayFair Dental Associates, PC and the staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to the practice, and to handle any necessary claim appeal(s) on my behalf

CANCELLATION POLICY: a 48 hour notice must be given to cancel or change an appointment. We reserve the right to charge a $75 fee for broken appointments with less than 48 hour notice. After two broken appointments, we reserve the right to require a deposit in order to make another appointment. After a third broken appointment we reserve the right to dismiss you from the practice.

Consent (Adult)

Name of patient_____ _____ **Date**_____

Signature of Patient

Consent(for a minor child):

Name of Parent/ Guardian _____ _____ **Date**_____

Signature of Parent/ Guardian

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ **Date** _____

Signature of Patient