

Bernier Dental

5420 Land O Lakes Blvd | Suite 103 • Land O Lakes, FL 34639

(813)601-1122

Medical History Update Form

Patient Name: _____
Last First MI Preferred Name

Address: _____

Mobile Phone: _____ Home Phone: _____
Email: _____

WOMEN ONLY: Are you pregnant? Yes No

Please indicate if you have experienced any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Acid Reflux, GERD |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro |
| <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Bone Density Meds |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemo Therapy | <input type="checkbox"/> Clotting Problems |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head/Jaw Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Valve Replaced |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> MVP |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pain Management Care |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | | |

Please list current medications and any other medical conditions/allergies.

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

*I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

*I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

*I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

*I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ Date _____

PLEASE COMPLETE BACKSIDE OF THIS FORM