Scott Mosby DDS, PC.

2420 Northpark Drive
Kingwood, Texas 77339

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Date: _____

Last Name: _____ First Name: _____

I prefer to be called: _____ Male/Female: _____

Address: _____Zip Code: _____

Home#: _____ Work #: _____ Cell #: _____

Email Address: _____

DOB: _____Marital Status: _____SS#_____

Who may we thank for referring you to our office? _____

Tell us what qualities are important to you in a dentist: _____

MEDICAL HISTORY

Are you now or have you recently been under a physician's care? ____yes ____no

Reason _____

Check any of the following medical conditions you may have or have had:

___ Arthritis	___ Hepatitis or Jaundice	___ Prolonged bleeding
___ Rheumatic Fever	___ Liver Disease	___ Fainting tendency
___ Heart trouble	___ Cancer or Tumor	___ Epilepsy
___ Heart Murmur or MVP	___ Tuberculosis	___ Thyroid Disease
___ High/Low blood pressure	___ Diabetes	___ Glaucoma
___ Chest Pain	___ Kidney/bladder trouble	___ Radiation treatment
___ Stroke	___ Anemia	___ Mental Disorder
___ Shortness of Breath	___ Lung Disease	___ HIV or AIDS
___ Asthma or Hay fever	___ Venereal Disease	___ Prosthetic joint replacement
___ Sinus trouble	___ Blood Disease	___ Blood Transfusion

Are you taking any medication? ____yes ___ no If yes, please list each one: _____

Are you allergic to anything? ___yes ___ no If yes, please list: _____

Are you pregnant? ____yes ___ no If yes, how many months? ___ Are you breast feeding? ___

☐ Yes, you may use my testimonial, photos and name to let other patients know about my great experiences with this office.

Person Responsible for Account: _____ Relationship: _____ SS#: _____

Billing Address: Zip Code: _____ _

Work#: Home#_____ Employer: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that may be needed during diagnosis and treatment, including but not limited to exam, x-rays, local anesthesia, photographs, nitrous oxide sedation, and administration of drugs prescribed by the dentist.

Patients signature: _____ Date: _____ Witness: _____

Scott ·Mosby, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)
