DIRK A. STERLEY, D.D.S.

6545 CARROLLTON AVE. • INDIANAPOLIS, IN 46220

(317) 251-1333

Date _____

CONFIDENTIAL MEDICAL HISTORY

Patient's Name _____
Last First MI Mr. Mrs. Ms. Dr.

Preferred Name _____ ❑ Male ❑ Female

Birthdate ____ / ____ / ____ Age: _____ SS# _____ DL# _____

Address _____

City/State/Zip _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated **Email** _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____ Ext _____

Employer's Address _____

How long there? _____ Occupation _____

Best way and time to reach you? _____ Other family members seen by us? _____

Whom may we thank for referring you? _____

Previous | Past Dentist: _____ Last Visit Date? _____
Please Circle

Spouse's Name _____

Employer _____ Work Phone _____ Ext _____

Birthdate ____ / ____ / ____ Age: _____ SS# _____ DL# _____

Person Responsible for Account: _____ Relationship _____

Address _____

City/State/Zip _____

Employer _____ SS# _____ DL# _____

PRIMARY INSURANCE Dental Coverage ❑ Yes ❑ No

Insurance Co. Name _____ Phone _____

Address _____

Group | Plan | Policy # _____ I.D. # _____

Insured's Name _____ Relation _____ Birthdate ____ / ____ / ____

Insured's Employer & Address _____

SECONDARY INSURANCE Dental Coverage ❑ Yes ❑ No

Insurance Co. Name _____ Phone _____

Address _____

Group | Plan | Policy # _____ I.D. # _____

Insured's Name _____ Relation _____ Birthdate ____ / ____ / ____

Insured's Employer & Address _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name _____ Relation _____ Home # _____

over please

PATIENT HEALTH RECORD

Physician _____ Approximate date of last physical exam _____

Do you now have, or have you ever had any of the following?

	YES	NO		YES	NO
Heart Disease	❑	❑	High Blood Pressure	❑	❑
Rheumatic Fever	❑	❑	Ulcers	❑	❑
Tuberculosis	❑	❑	Diabetes	❑	❑
Glaucoma	❑	❑	Epilepsy-Convulsions	❑	❑
Heart Murmur	❑	❑	Anemia	❑	❑
Hepatitis	❑	❑	Tumors or Growths	❑	❑
Kidney Disease	❑	❑	Prolonged Bleeding	❑	❑
Chest Pains	❑	❑	Fainting Spells	❑	❑
Thyroid Trouble	❑	❑	AIDS - HIV positive	❑	❑
Open Heart Surgery	❑	❑	Osteoporosis	❑	❑

	YES	NO
Are you now taking Bisphosphonates?	❑	❑
Are you now being treated by a physician or any health care profession?	❑	❑
If so, please explain: _____		
Are you allergic, or have you had an unusual reaction to any drug?	❑	❑
Have you ever had an adverse reaction to Novocaine or Penicillin?	❑	❑
Are you now taking any drugs or medications? If so, what and how much?		
a: _____ b: _____ c: _____ d: _____ e: _____		
Have you ever experienced excessive or prolonged bleeding?	❑	❑
Have you ever experienced slow healing of a wound or incision?	❑	❑
Do you have an artificial limb or joint?	❑	❑
Do you have an artificial heart valve?	❑	❑
Do you have a pacemaker?	❑	❑
Are you pregnant? If so, what is your due date?	❑	❑
Do your gums bleed easily, feel tender or irritated?	❑	❑

Are your teeth sensitive to: Hot ❑ Cold ❑ Sweets ❑

Is there anything of importance in your medical history that the Doctor should know or be made aware of?

_____

Signature of Patient (Guardian) _____ Date _____

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 my medical status.

Signature of Patient _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand I am responsible for all costs of dental treatment. I hereby authorized release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of Patient _____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.