MEDICAL HISTORY FORM

(Print Only - Ink Only - Circle Correct Answers)

Patient's Full Legal Name _____ **Patient** Birth Date _____

Does Patient have a **COURT APPOINTED** Legal Guardian (LG) or **ACTIVATED** Power of Attorney (POA) ? YES NO

If Yes : The LG/POA contact info is required and the LG/POA will need to sign all forms !

(LG/POA Name) _____

(LG/POA Phone #) _____(LG/POA Address)_____

Patient's Physician Name _____Physician's Phone #_____

Patient's Physician Address _____

Patient's Pharmacy and City of Pharmacy_____

Does patient's physician advise patient take **Antibiotics** before dental appointments ? YES NO

Is patient taking any **Bisphosphonate** drugs (usually taken to treat **Osteoporosis**) ? YES NO

[examples : Alendronate Fosamax Binosto, Risedronate Actonel Atelvia, Ibandronate Boniva, Zoledronic Acid Reclast Zometa Aclasta]

Is patient taking **Blood Thinners** ? YES NO

[examples : Warfarin Coumadin, Dabigatran Pradaxa, Rivaroxaban Xarelto, Apixaban Eliquis, Fondaparinux Arixtra, Heparin Lovenox , Edoxaban Savaysa]

Has patient ever had an **Allergic Reaction** to any of the following ? (Circle all that apply)

PENICILLIN CEPHALEXIN CLINDAMYCIN AZITHROMYCIN CODEINE OXYCODONE (Percocet)

ACETAMINOPHEN (Tylenol) IBUPROFEN (Advil) NAPROXEN (Aleve) HYDROCODONE (Vicodin - Norco)

List all other drug allergies patient may have :

CIRCLE any of the following conditions patient has had in the past (or) may have at the present :

Prosthetic Heart Valve
Heart Valve Repair
History of Endocarditis
Heart Transplant
Congenital Heart Defect
Heart Pacemaker
Artificial Joint
Psychiatric Treatment
Weakened Immune System
Donor Organ Recipient
AIDS and/or HIV Positive
Chemotherapy
Radiation Treatment
Alcoholism
Drug Addiction
Hepatitis B or C
COVID-19
Coronavirus

Does patient have any other disease, condition, or medical problem not listed above ? Is there anything else we should know about the patient's health that has not been covered in this form ? YES NO If Yes, explain below, use back if needed :

I certify that the answers given to the questions asked in this **Medical History Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Patient Medication Form (page 2)

Print Only – Ink Only – Circle Correct Answers

Print Patient's Full Name : _____

Is patient taking any Illegal drugs ? YES NO If, yes list drug(s) :

Is patient taking any prescription, OTC (over the counter), or herbal medications ? YES (List Below) NO

Drug or Medication Name	Dosage	Frequency of Use	Reason for Taking Drug or Medication
Example : Atenolol	Example : 100 mg	Example : Twice per day	Example : High Blood Pressure

I certify that the answers given to the questions asked in this **Patient Medication Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

RECERTIFICATION, CONTINUING CONSENT FOR TREATMENT, AND COVID-19 SCREENING FORM (page 3)

Print Full Legal Name of Patient _____

Does Patient have a **COURT APPOINTED** Legal Guardian (LG) or **ACTIVATED** Power of Attorney (POA) ? YES NO

Print LG/POA Name : _____

LG/POA Phone #s _____

1. Does patient have a fever ? YES NO
2. Has patient been in contact with an individual diagnosed with COVID-19 in the last month ? YES NO
3. Has patient been diagnosed with COVID-19 in the last month ? YES NO
4. Has patient been tested for COVID-19 ? YES NO
5. Has patient traveled outside the U.S.A. in the last month ? YES NO
6. Is patient experiencing any respiratory problems such as abnormal coughing or shortness of breath ? YES NO

Medical Changes – Drug Changes – Other Changes :

I certify that there have been no changes in the above named patient's medical history, dental history, registration information, general information, dental insurance, or any other applicable information, except as noted below. I certify the patient has not stopped, started, or changed any prescription or over-the-counter medications, except as noted above. I certify the patient has not suffered any illnesses or injuries since the patient's last visit, except as noted above. I certify all medical treatments or consultations the patient has had since their last dental visit has been listed above. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions that may have been made in completion of this form. I hereby authorize Dr. James J. Herget and whomever he designates as his dental hygienists and assistants to perform dental treatment on the above named patient. I give my continuing consent to all advisable and necessary dental procedures needed for diagnostic purposes and dental treatment. I further consent to the administration of local anesthetics, antibiotics, analgesics, or any other drugs that may be deemed necessary by Dr. James J. Herget. I agree Dr. Herget will not be held responsible for any sub-standard treatment or complications from treatment done by another provider such as a dental specialist. I understand that female patients taking birth control pills need to find an alternative method of birth control should Dr. Herget prescribe antibiotics, as the antibiotic may inactivate the birth control pills effectiveness. I certify that the answers given to the questions asked in this **Recertification, Continuing Consent for Treatment, and COVID-19 Screening Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____