My current **MEDICAL** health is:

❑ excellent ❑ good ❑ poor

Are you under the care of a physician? ❑ No ❑ Yes

Physician Name ___________________________________

Office location ____________________________________

Office telephone ___________________________________

List all medications you take (prescription <u>and</u> over counter)

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Have you ever had the following?

❑ Heart Attack	❑ Heart Surgery	❑ Mitral Valve Prolapse
❑ Heart Murmur	❑ Pacemaker	❑ Rheumatic fever
❑ Scarlet Fever	❑ Hepatitis	❑ Kidney Problems
❑ Cancer	❑ Chemotherapy	❑ Radiation Treatment
❑ HIV / Aids	❑ Shingles	❑ Artificial Joint
❑ Fever Blisters	❑ Cold Sores	❑ Artificial Valve
❑ Stroke	❑ Sinus Trouble	❑ Epilepsy / Seizures
❑ Diabetes	❑ Tuberculosis	❑ Psychiatric Problems
❑ Ulcers	❑ Colitis	❑ Drug/Alcohol Dependence
❑ Anemia	❑ Asthma	❑ Hemophilia / Bleeding
❑ Arthritis	❑ Emphysema	❑ Venereal Disease
❑ Fainting	❑ Glaucoma	❑ Difficulty Breathing

❑ Hospitalized ___________________________________
❑ High / Low Blood Pressure
❑ Blood Transfusion
❑ Severe or Frequent Headaches ____________________

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<u>*Are you Allergic to or have had difficulty with any of the following substances....</u>**

❑Penicillin	❑Tetracycline	❑Latex
❑Aspirin	❑Codeine	❑Dental Anesthetic
❑Sulfa	❑Erythromycin	

❑Other Drugs ____________________________________

Do you exercise regularly ❑ Yes ❑No

If YES what do you enjoy doing?____________________

For Women

Are you taking birth control pills	❑ No ❑Yes
Are you pregnant	❑ No ❑Yes
Are you nursing	❑ No ❑Yes

<u>Informed Consent</u>

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment of professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

All past due amounts are assessed 3% per month

SIGNED ________________________________**DATE** ______

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call (727) 796-1767

<u>Dental Insurance Information and Agreement</u>

As a service to our valued patients WE SUBMIT TO ALL INSURANCE COMPANY PLANS AND FILE ALL INSURANCE CLAIMS FOR YOU ELECTRONICALLY.

<u>A SIGNED AND COMPLETED INSURANCE FORM IS REQUIRED FOR OUR FILES.</u>

The responsibility of the insurance company is to you and it is important that you insure you are reimbursed properly. Fees for services provided to insured patients are the usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage stated by your insurance company or different than the percentage listed in your benefit booklet. Dr. Obman has developed fees based on services provided and does not participate with insurance carriers in determining appropriate fees. In deciding whom he should participate with, the doctor has selected YOU. We will do our very best to be certain that you receive all of the benefits due to you from your insurance carrier, if you have questions please contact us at (727) 796-1767.
I wish to have you file my claims electronically. I have read the above completely and agree to the arrangements stated.

SIGNED ________________________________**DATE** ______