Brian E. Barrett D.M.D., P.C.
Family & Cosmetic Dentistry

3080 US Highway 231
Wetumpka, AL 36093

Medical History List

Name: ____ **Reason for this visit:** ______________________________

Allergies: Seasonal
Allergy: Medication
Penicillin
Codeine
Sulfa
Other ________
Arthritis/Rheumatism
Artificial Joints
Surgery & Dates: _____
Blood Disorder/Disease
Anemia
Excessive Bleeding

Cancer/Tumors
Radiation Treatment
Diabetes – Type: ______
Glaucoma
Head Injuries: Date _____
Heart Attack: Date _____
Stroke: Date ______
Heart Disease
High Blood Pressure
Pacemaker Date ___
Heart Murmur/MVP
Hepatitis: Type ______

HIV/AIDS
Kidney Disorder/Disease
Liver Disease
Mental Disorders
Special Needs
Nervous Disorder/Anxiety
Dizziness/Fainting
Epilepsy
Panic Attacks
Pregnant Now: Due _____
Respiratory Problems
Asthma

Sinus Problems
Tuberculosis
Rheumatic Fever
Stomach Problems/Ulcers
Crohn's Disease
Thyroid Disorder/Disease
Other:
____
____

LIST ALL CURRENT MEDICATIONS: ____

____

Have you ever had complications following dental treatment? Yes No
If yes, please explain: ____
Are you currently being treated by a physician for a medical problem? Yes No
If yes, please explain: ____
Have you been admitted to a hospital or needed emergency care in the past two years? Yes No
If yes, please explain: ____
Do you have any health problems that need further clarification? Yes No
If yes, please explain: ____
Name of Primary Care Physician: ______________________________ Phone: ________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangement, must be paid for in full at the time of the services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by the insurance company, so any balance not paid is the patient's responsibility. I agree to pay therefore for the service of said doctor, at the time services are rendered. I further agree that a waiver of any breach of any time or condition hereof shall constitute a wavier of any further term or condition and I further agree to pay all costs due to the collection agency and/ or attorney should my account be turned over. I grant my permission to you or your assignee, to telephone me at home, work, or on my cell phone to discuss my account at this office. I have read the conditions of treatment and payment and agree to their content.

____ __________ ____________________
Signature of Patient or Parent/Guardian and Guarantor of Payment **Date** **Relationship to Patient**

____ ____________
Signature of Doctor **Date**