# Medical History

Dr. Stephen D Poss, DDS, AASM, AASDM

Height ________________ Weight_______________

**Please circle if you have any of the following:**

| | | |
|---|---|---|
| Anemia | Heart Murmur | Heart Disorder |
| Heart Attack | Stroke | Mitral Valve |
| Arteriosclerosis | Heart Pacemaker | Osteoarthritis |
| Asthma | Heart Burn | Poor Circulation |
| Autoimmune Disorder | Hepatitis | Recent Weight Gain |
| Excessive Bleeding | High/Low Blood Pressure | Blood disease |
| Have you worn Braces | HPV | Arthritis |
| Chronic Sinus problems | Immune System Disorder | Rheumatic Fever |
| Chronic Fatigue | Injury to Head | Swollen or Stiff Joints |
| Injury to Neck | Injury to Teeth | Irregular Heart Beat |
| Shortness of Breath | Congestive Heart Failure | Difficulty Concentrating |
| Diabetes | Thyroid Problems | Anxiety |
| Heart Pounding | Tonsillectomy | Emphysema |
| Jaw Joint Surgery | Wisdom Teeth Extracted | Epilepsy |
| Dizziness | Memory Loss | Acid reflux |
| Migraines | Morning Dry Mouth | Hay Fever |
| Muscle Spasms or Cramps | Fibromyalgia | Alcohol use |
| Frequent Sore Throat | Nighttime Sweating | Sleep Aids |
| Insomnia | Bipolar Disorder | Tobacco/Erb Use |
| Drug Abuse | Cancer | Respiratory problem |
| Artificial Joint | Pre-Med | |

**Allergic to any of the following:**

**Aspirin** **Sulfa** **Penicillin**

**Tetracycline** **Latex** **Codeine**

**Dye's**

Notes: ______________________________________________________________________________

**Medicine you are taking:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________

*Has CPAP been prescribed to you?* __________________________________________

*Are you able to wear it?* ________________________________________

*Do you snore?* _____________________________________________

*Have you had a Sleep Study?* _______________________ *Where* _______________________________

*Would you be interested in talking to Dr. Poss about an alternative to the CPAP?*

_________________________________________________

*If you are seeing Dr. Poss for the Sleep Appliance do you have a general dentist?* ________________

*If not would you be interested in having Dr. Poss as your Family Dentist* _______________________

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health I will inform the office at my next dental appointment without fail.

***Authorization***

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize Dr. Stephen Poss to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, Payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or the dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: ___________________________________ Date_____________________

Relationship to patient___________________________