Ricardo A. Perez, D.D.S, P.C

Medical History

Now that you have turned 18 years old we are pleased to welcome you to our office as a young adult. Please take a few moments to fill out this form front and back completely. If you have any questions we'll be glad to assist you.

First name: _____ Last name: _____ Middle initial: _____

Preferred name: _____ E-mail: _____ Gender: Male ◯ Female ◯

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____-_____ DOB: _____/_____/_____ Age: _____

***Primary Physicians name*:** _____ Phone No. (_____)_____-_____

Emergency contact information

Name: _____ Phone number: (_____) _____-_____Relationship: _____

Medical History

Please check if you have had, or have been diagnosed with any of the following:

- ☐ AIDS / HIV positive
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Food Allergies: _____
  _____
- ☐ Heart murmurs
- ☐ Heart problems: _____
  _____
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Hepatitis
- ☐ Jaw pain
- ☐ Kidney Disease or Malfunction
- ☐ Liver Disease
- ☐ Material Allergies: _____
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Surgical Implant
- ☐ Tuberculosis / TB
- ☐ Other (please explain):_____
  _____
  _____

Please see back

Are you on a special diet? No ◯ Yes ◯ Do you use Tobacco in any form? No ◯ Yes ◯

Taking Oral Contraceptives? No ◯ Yes ◯

Any conditions not listed you would like to bring to our attention: _____

_____

_____

I have read the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Perez to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Perez.

Late Cancellation Policy

A great deal of planning is done for your appointment. Changes and cancellations to our schedule without adequate notice are very disruptive to our office, and to other patients waiting for appointments. For this reason, we ask that any changes to your appointments be made AT LEAST 48 HOURS in advance and 72 HOURS if appointment is on a Monday or Tuesday. If this policy is not followed a $100 fee per appointment will be charged to your account, paid prior to rescheduling.

Treatment Authorization

I hereby give authorization to Ricardo A. Perez, D.D.S, P.C., for the completion of all agreed upon dental services.

Initial: _____

Electronic E-Mail Consent

I acknowledge Metropolitan Pediatric Dentistry may send information regarding my treatment, consultation notes, and radiographic images, via standard (unencrypted) Electronic Mail (E-Mail) to other doctors involved in my care, and or to me, upon request.

Initial: _____

Privacy Practices Acknowledgement/HIPPA

I have received and reviewed a copy of the dental practice's privacy, security and breach notification policies and procedures. I understand that should I have any questions regarding these policies and procedures, I have the right to ask the practice's Privacy Official.

Initial: _____

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I accept full financial responsibility for all charges for services or items provided to me.

Initial: _____

/ /

Signature Date