Waverly Dental
Alexay Tamas, DMD

721 Waverly Dr. SE
Albany, OR 97322
(541) 928-8434

Name: _____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birthdate:_____ Age:_____ Email:_____

Primary Dental Ins:_____ Ins. ID:_____

Secondary Dental Ins:_____ Ins. ID:_____

MEDICAL HISTORY UPDATE:

Physician's name:_____ Date of last physical:_____

Have you had any serious illness or operations? __ No / Yes__ If Yes, describe:_____

(Women) Are you pregnant? __No / Yes__ Nursing? __No / Yes__ Taking birth control pills? __No / Yes __

Do you require antibiotics prior to dental treatment? ___No / Yes___

Please check if you have or have had any of the following:

__ AIDS
__ Alzheimers, dementia, memory loss
__Anemia
__Artificial joints
__Artificial heart valve
__Asthma
__Back problems
__Blood disease
__Cancer
__Chemical dependency
__Chemotherapy
__Circulatory problems
__Cortisone treatments
__Cough, persistent
__Diabetes
__Epilepsy
__Fainting
__Fibromyalgia
__Glaucoma
__Headaches
__Heart murmur
__Heart problems
__Hemophilia
__Hepatitis
__High blood pressure
__High cholesterol
__HIV Positive
__Kidney disease
__Latex allergy
__Liver disease
__Mitral valve prolapse
__Nervous problems
__Osteoporosis
__Pacemaker
__Parkinson's disease
__Psychiatric care
__Respiratory diseases
__Radiation treatment
__Rheumatic Fever
__Shortness of breath
__Skin rash
__Stroke
__Thyroid problems
__Tobacco habit
__Tonsillitis
__Tuberculosis
__Ulcer
__Venereal disease

Other? Describe:_____

MEDICATIONS:_____ **ALLERGIES:_____**

_____ _____

_____ _____

AUTHORIZATION AND RELEASE:

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of patient, or parent if patient is a minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.