Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Rheumatic Fever
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe _____	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

MEDICATIONS

List Medications you are currently taking:

_____ _____

_____ _____

ALLERGIES

Authorization

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, CHRISTOPHER M. SALMON, D.M.D., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/WE have read this disclosure and agree that CHRISTOPHER M. SALMON, D.M.D., its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signatue Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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.

How do you wish for us to handle your account? ___ cash or check ___ credit card ___ Insurance ___ Carecredit

If payment is not received within 45 days, this account will be turned over for collection and I hereby agree to waive any and all rights to claim personal property as exempt from levy under the law of the State of Alabama. Also, I agree to accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

I understand all of the above information and hereby consent for Dr. Christopher M. Salmon and staff to provide dental treatment.

_____ _____

Responsible Party Signature **Date**