WENATCHEE VALLEY DENTAL VILLAGE
A Wonderful World For Dentistry
General Dentistry for Children & Young Adults
Nelson & Reynolds, PLLC

Medical History Update

Patient name: _____ Phone Number _____

Date of birth _____ Age____ Wt.____ Ht.____ Sex____ Email: _____

Physician's Name _____ Today's date: _____

Are you presently in good health? ☐ Yes ☐No

If no, please explain

_____

Past serious illnesses? ☐Yes ☐No

If yes, please explain

_____

Have you been admitted to a hospital overnight within the past year? ☐Yes ☐No

If yes, please explain _____

List all medications you take including OTCs and herbal remedies:

_____

Allergies to medications? ☐Yes ☐No

If yes, please list

_____

Date of last physical exam _____

Is there a chance you are pregnant? ☐Yes ☐No

Are you using birth control pills? ☐Yes ☐No

Have you ever had a blood transfusion? ☐Yes ☐No

List all surgeries in the past

_____

Have you or any family member ever experienced a reaction to anesthesia? ☐Yes ☐No

If yes, how much and for how long?

_____

Do you have diabetes? ☐Yes ☐No

If yes, please explain?

_____

Do you have sleep apnea? ☐Yes ☐No

If yes, how much and for how long?

_____

Do you have high blood pressure? ☐Yes ☐No

If yes, how much and for how long?

_____

Justin R. Nelson, DMD • Thomas L. Reynolds, DDS
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As the legal guardian or executor of the patient named below, I hereby authorize Nelson & Reynolds, PLLC, d/b/a Wenatchee Valley Dental Village, to request the following information for:

Patient's Full Name: _____

Date of Birth: _____

Social Security Number: _____

Dates of Treatment: _____

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment records, referral and consultation recommendations and reports, and other related materials.

I also allow the taking of photographs to establish dental conditions or, with obscured identity, for educational purposes.

Reason for Releasing Records: _____

As the legal or natural guardian or executor of the above referenced patient, I hereby permit the release of all information indicated above. I understand that the patient's medical information is confidential and protected by Federal and State privacy laws and regulations. As the legal or natural guardian or executor of the above referenced patient, I hereby waive the above named patient's right and privileges relating to the patient protected and confidential health information. I agree to hold Nelson & Reynolds, PLLC harmless from any and all liability, damage and expense relating to the disclosure of the patient's medical and dental information as authorized above.

I understand that I may revoke this authorization at any time, except to the extent that prior action has been taken on this authorization. This consent will expire 60 days from the date it is signed if not revoked sooner.

I further release the attending doctor, his (her) associates and staff, from any and all liability arising from compliance with this request and disclosure of the requested information.

I have received a copy of the Notice of Privacy Practices.

Dated: _____

Signed: _____

Printed Name: _____

Relation to Patient: _____

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