

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

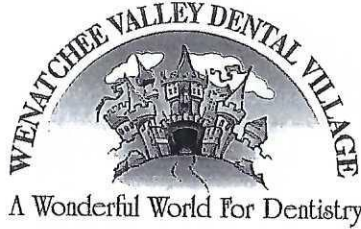
*If yes, please explain?*

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?*



### 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: \_\_\_\_\_

*General Dentistry for Children & Young Adults*

Nelson & Reynolds, PLLC

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