Family Medical History

Please circle any condition that applies to your parents.

Heart Disease	Stroke	High Blood Pressure
Low Blood Pressure	Diabetes	Cancer________________.
Heart Attack	Pre-Term Birth	Gum Disease
Tooth Loss	Dentures	

Note: Both the doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

____________________________________. ________________

Signature of Patient or Legal Guardian Date

For Completion by Dentist

Comments on patient interview concerning health history:______________________________

____

____

Significant findings:____

____

____

Dental management considerations: ____

____

____

Health History Update

Date	Comments	Patient & Dentist Signature
____	__________________________________	_________________________
____	__________________________________	_________________________

Authorization to Release Health Care Information

Because of the Oral-Systemic Connection, I would like your permission to co-manage your case with your physician, endocrinologist or cardiologist. I will be advising your medical team of your test results, before and after your periodontal treatment.
Should they have any concerns about the results, they will contact you for additional diagnostic tests or for an appointment.

I _____________________ hereby give Dr. Suhail Mati my consent to share the results of my assessment and blood tests, as well as my treatment plan and outcomes with my physician(s) named below:

Physician Name:

_______________________________ Phone #: _____________

Address:

____

Physician Name:

_______________________________ Phone #: _____________

Address:

____

Physician Name:

_______________________________ Phone #: _____________

Address:

____

I request and authorize doctors listed above to release health care information to the physicians listed above. I understand that my express consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If any of these apply, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

______________________________________ ___________________

Patient Signature Date