



**MEDICAL HISTORY**

Circle one

Are you now or have you been under a physician's care during the past two years?.....Yes No

Are you subject to prolonged bleeding?.....Yes No

Have you ever experienced difficulty healing from cuts or surgery?.....Yes No

Do you currently have Diabetes?.....Yes No

Is there a family history of Diabetes?.....Yes No

Do you currently smoke tobacco?.....Yes No

Have you ever smoked tobacco?.....Yes No

Have you ever experienced ill effects from Novocaine, Penicillin, Codeine, shellfish, Aspirin, adhesive tape or any other medications?.....Yes No  
If yes, which ones? \_\_\_\_\_

Have you ever been treated for: Heart trouble; Arthritis; Asthma; Epilepsy; Rheumatic fever; kidney or liver problems; high blood pressure; gout?.....Yes No  
If yes, which ones? \_\_\_\_\_

Have you ever had any serious illnesses or operations?.....Yes No  
If yes, please explain: \_\_\_\_\_

Do you need to take antibiotics prior to seeing your dentist?.....Yes No

Have you ever received a blood transfusion?.....Yes No

What medications are you presently taking? \_\_\_\_\_

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**INSURANCE CLAIMS PROCESSING DISCLAIMER  
AND CONSENT FOR TREATMENT**

1. By signing below, I certify that the above information, to the best of my knowledge, is true and correct.
2. I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical benefits to Dr. Jordan S. Sheff for any services rendered. In order to more smoothly and efficiently process third party insurance claims, I hereby give permission to release my insurance information. Such information is only to be released for the purpose of filing health insurance claims to insurance companies and related agencies.
3. By signing below, I also understand that although I may participate in a health insurance plan, that I am wholly responsible for payment of services rendered if my insurance carrier fails to pay for all or a part of services rendered.
4. I hereby give my permission to Dr. Jordan S. Sheff to examine and perform such procedures as may be deemed necessary by him and myself in the diagnosis and care for my foot condition.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Relationship To Above:** \_\_\_\_\_