

MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

1. Are you experiencing pain or discomfort at this time? Yes No

2. Do you smoke? Yes If yes, how much? _____ No

3. Are you currently taking any medications or drugs? Yes No

If yes, please list: _____

4. Are you sensitive or allergic to any medications or anesthetics? Yes No

If yes, please list: _____

5. Indicate which of the following you have had or have at present. Please circle "yes" or "no" for each.

Allergy to Latex	Yes No	Artificial Joints	Yes No	Venereal Disease	Yes No
Heart Failure	Yes No	Kidney Trouble	Yes No	A.I.D.S.	Yes No
Heart Attack or Disease	Yes No	Ulcers	Yes No	H.I.V. Positive	Yes No
Angina Pectoris	Yes No	Diabetes	Yes No	Cold sores / Fever Blisters	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	Blood Transfusion	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	Hemophilia	Yes No
High Blood Pressure	Yes No	Cancer	Yes No	Anemia	Yes No
Arteriosclerosis	Yes No	Emphysema	Yes No	Sickle Cell Disease	Yes No
Mitral Valve Prolapse	Yes No	Chronic Cough	Yes No	Bruise Easily	Yes No
Artificial Heart Valve	Yes No	Tuberculosis	Yes No	Liver Disease	Yes No
Heart Pacemaker	Yes No	Asthma	Yes No	Yellow Jaundice	Yes No
Heart Surgery	Yes No	Hay Fever	Yes No	Epilepsy / Seizures	Yes No
Rheumatic Fever	Yes No	Allergies/Hives	Yes No	Fainting/ Dizzy Spells	Yes No
Arthritis	Yes No	Sinus Trouble	Yes No	Nervousness	Yes No
Cortisone Medicine	Yes No	Radiation Therapy	Yes No	Tumors	Yes No
Drug Addiction	Yes No	Chemotherapy	Yes No	Developmentally Disabled	Yes No
Stroke	Yes No	Hepatitis A (infectious)	Yes No		
		Hepatitis B (serum)	Yes No		

6. Do you experience chest pain or shortness of breath when walking up stairs? Yes No

7. When sleeping, do you use more than two pillows? Yes No

8. Have you lost or gained more than 10 lbs. during the last year? Yes No

9. Are you on a special diet of any kind? Yes No

10. Are you ever short of breath after waking up from sleep? Yes No

11. Do you have any sickness, condition, or problem that is not listed? Yes No

If Yes, please explain. _____

WOMEN ONLY:

Are you pregnant? Yes, what month? _____ NO Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand that this information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature (or Guardian) _____ Date _____

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all mutually recommended treatment agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. I also authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in the office for myself or my dependants is mine, due and payable at the time of service unless other arrangements have been made in advance. If payments are not received by the agreed upon dates, I understand that a 1-1/2 % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent Or Responsible Party _____ Relationship to Patient _____

For Office use only: Reviewed by Dr. _____ Date _____