

Medical History

Patient Name _____

Date of Birth _____ Last Complete Medical Exam _____

Family Physician _____ Phone _____

Additional Physician _____ Phone _____

Have you taken any medications in the last two years? _____

List all medications you are currently taking (or provide a list) _____

Are you aware of having an allergic (or adverse) reaction to any medication or substance? _____

If yes, please list _____

Have you been hospitalized during the past five years? _____

Please check all of the following conditions you have had, or have at present:

- | | | |
|---|---|--|
| <input type="checkbox"/> Alcohol dependency | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Allergy or hives | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous/Anxious |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Radiation/Chemo |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart (Surgery, Disease) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Heart Murmur Requiring Antibiotics | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A,B, other | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Supervised Diet |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> HIV Positive/AIDS | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Chest pain/Angina | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Tobacco Dependency |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Disease | | <input type="checkbox"/> Ulcers |

Do you use more than two pillows to sleep? _____ Do you use a CPAP machine? _____

Have you lost or gained more than ten pounds in the past year? _____

Do you have, or have you had any disease, condition, or problem not listed? _____

WOMEN: Are you: Pregnant? _____ Months _____ Nursing? _____ Taking Birth Control? _____

ASSIGNMENT AND RELEASE

*I hereby authorize my insurance benefits to be paid directly to the dentist. I acknowledge that I am financially responsible for all charges. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if she so determines.

*In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its policies.

*I consent to the taking of photographs and x-rays before, during, and after treatment, as needed for care if previous dentist does not send current films.

*I certify that I have read or have had read to me the contents of this form and do realize the risks and limitations involved.

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____