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:

__Alcohol dependency
__Allergy or hives
__Anemia
__Artificial Heart Valve
__Artificial Joints
__Arthritis/Rheumatism
__Heart (Surgery, Disease)
__Scarlet Fever
__Sinus Trouble
__Asthma
__Blood Disorder
__Cancer/Tumors
__Chest pain/Angina
__Chronic Cough
__Communicable Disease
__Congenital Heart Disease

__Cortisone Medication
__Diabetes
__Drug Dependency
__Emphysema
__Epilepsy or Seizures
__Fainting or Dizzy Spells __Glaucoma
__Hay Fever
__Heart Murmur Requiring Antibiotics
__Heart Pacemaker
__Hepatitis A,B, other
__High Blood Pressure
__HIV Positive/AIDS
__Kidney Trouble
__Latex Sensitivity
__Liver Disease/Jaundice

__Mitral Valve Prolapse
__Nervous/Anxious
__Neurological Disorder
__Psychiatric Care
__Radiation/Chemo
__Rheumatic Fever
__Shortness of Breath
__Sleep Apnea
__Stroke
__Supervised Diet
__Swollen Ankles
__Thyroid Disease
__Tobacco Dependency
__Tuberculosis
__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 hearby 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, and to the use of same by the doctor in scientific papers or demonstrations.
*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______________________