Medical History

Are you taking any of the following medications? e ˙Nerve Pills e ˙Pain Killers (Including Aspirin) e ˙Muscle Relaxers

e ˙Stimulants e ˙Blood Thinners e ˙Tranquilizers e ˙Insulin

e ˙Other(s), please list: ______________________________

Do you or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Sinus Problems	**Y N** Severe / Frequent Headaches
Y N Heart Surg. / Pacemaker	**Y N** Stomach Problems / Ulcers	**Y N** Frequent Neck Pain
Y N Heart Murmur	**Y N** Psychiatric Problems	**Y N** Back Problems
Y N Rheumatic Fever	**Y N** Venereal Disease	**Y N** Cosmetic Surgery
Y N Mitral Valve Prolapse	**Y N** Alcohol / Drug Abuse	**Y N** Xray or Cobalt Treatment
Y N Artificial Valves	**Y N** Tuberculosis TB	**Y N** Chemotherapy
Y N Heart Disease	**Y N** Jaw Problems TMJ / TMD	**Y N** Asthma
Y N Congenital Heart Defect	**Y N** Cancer / Tumors	**Y N** Difficulty Breathing
Y N Chest Pains	**Y N** Shingles	**Y N** Diabetes / Hypoglycemia
Y N Scarlet Fever	**Y N** Hepatitis	**Y N** Leukemia
Y N Nervousness	**Y N** HIV+ / AIDS / ARC	**Y N** Anemia
Y N Thyroid Problems	**Y N** Arthritis / Rheumatism	**Y N** High / Low Blood Pressure
Y N Kidney Problems	**Y N** Artificial Bones / Joints	**Y N** Bleeding Problems
Y N Liver Problems	**Y N** Emphysema	**Y N** Glaucoma
Y N Respiratory Problems	**Y N** Fainting / Seizures / Epilepsy	

Please list any other surgeries or medical conditions you have or ever had: ______________________________

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Are you allergic to any of the following? e ˙Latex e ˙Penicillin / Amoxicillin e ˙Tetracycline e ˙Aspirin

e ˙Dental Anesthetics e ˙Others: ______________________________

Do you use tobacco? e ˙No e ˙Yes/How used? ____________ How much? ____________ How long? ____________

Please rate your health from 1-10: ____________ Do you wear contact lenses? e Yes e ˙No

Have you ever taken the drug Phen-fen and or Redux? e ˙Yes e ˙No

For women: Are you taking Birth Control Pills? e ˙Yes e ˙No How many children have you had? ____________

Are you pregnant? e ˙No e ˙Yes / How long? ____________ Are you nursing? e ˙Yes e ˙No

- We invite you discuss with us any questions regarding our services. The best Dental Health Services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date _____ / _____ / _____

e ˙Adult Patient e ˙Parent or Guardian e ˙Spouse

UPDATE
(OFFICE USE)

_______ ___ / ___ / ___
Initials
____
Comments

_______ ___ / ___ / ___
Initials
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Comments

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Initials
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Comments