MEDICAL HISTORY

PATIENT PLEASE COMPLETE

1. When were your teeth cleaned last? _____
2. Are you having pain or discomfort in any of your teeth? …….. YES NO
3. Do you feel nervous about having dental treatment? ……. YES NO
4. Have you ever had a bad experience in a dental office? ……..… YES NO
5. Have you been a patient in the hospital during the last two years? …… YES NO
6. Have you been under the care of a medical doctor during the past two years for other than routine exams, and if so, WHY? ……. YES NO
7. Are you taking any medicine of drugs? (If so, name)…… YES NO
8. Are you allergic to or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medications? Please describe _____ YES NO
9. Have you ever taken Phen Phen or Redux Medicines?……..…… YES NO
10. Have you ever had any excessive bleeding requiring special treatment? ……. YES NO
11. Have you ever had any of the medical conditions listed below? ……..……. YES NO

*** Please answer YES or NO***

*** REQUIRES PREMEDICATION**

YES	NO		YES	NO		YES	NO		YES	NO	
		Artificial Heart Valve*			Stroke			Chemotherapy			Hepatitis A
		Heart Murmur*			Kidney Trouble			Liver Disease			Hepatitis B
		Rheumatic Fever*			Ulcers			Arthritis			HIV
		Mitral Valve Prolapse*			Emphysema			Rheumatism			Yellow Jaundice
		Artificial Joint*			Tuberculosis			Glaucoma			Blood Transfusion
		Congenital Heart Lesions			Asthma			Epilepsy or Seizures			Drug Addiction
		Heart Pacemaker			Sinus Trouble			Fainting or Dizzy Spells			Hemophilia
		Heart/Bypass Surgery			Allergies			Sickle Cell Disease			Syphilis
		Heart Disease/Attack			Diabetes			Psychiatric Treatment			Gonorrhea
		Angina Pectoris			Thyroid Disease			Bruise Easily			Cold Sores
		High Blood Pressure			Scarlet Fever			Periodontal Disease			Herpes

11. When you walk up stairs, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?…… YES NO
13. Do your ankles swell during the day?……... YES NO
14. Has your medical doctor ever said you have cancer or a tumor? …… YES NO
15. Do you have any disease, condition, or problem not listed? If so, name…… YES NO
16. Do you smoke or use tobacco?……. YES NO
17. WOMEN: Are you pregnant now?…….. YES NO
    If yes, how many months? _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____ _____

Date **Dr. Signature** **Signature of Patient, Parent or Guardian**

Date **Addition** **Patient Signature** **Dr. Signature**

_____ _____ _____ _____