

## 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) \_\_\_\_\_

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

Do you use more than two pillows to sleep? \_\_\_\_\_

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? \_\_\_\_\_

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### 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, 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 \_\_\_\_\_