MEDICAL HISTORY

Patient Name:_____

Physician Name:_____ Office Phone _____Date of last exam_____

Are you currently under medical treatment? Yes No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes please explain:

_____

_____

Are you currently taking any medication (s) including any non prescription medicine? If yes please list medication(s):

_____ _____

_____ _____

Are you allergic to or have you had a reaction to any of the following? Please circle all that apply:

Local Anesthetics	Iodine
Aspirin	Penicillin
Sulfa Drugs	Any Metals (nickel, mercury, etc)
Barbiturates	Latex Rubber
Sedatives	Other_____

Please answer yes or no to the following questions:

Have you ever taken Fen-Phen/Redux?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No
Are you wearing contact lenses?	Yes	No
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes	No
Are you pregnant or think you may be?	Yes	No
Nursing	Yes	No
Taking oral contraceptives	Yes	No

Do you have or have you had any of the following, CIRCLE ALL THAT APPLY:

High Blood Pressure	Chest Pains	Hay Fever/Allergies
Heart Attack	Stomach Troubles/Ulcers	Tuberculosis
Rheumatic Fever	Heart Disease	Therapy
Swollen Ankles	Cardiac Pacemaker	Glaucoma
Fainting/Seizures	Heart Murmur	Recent weight Loss
Asthma	Angina	Liver Disease
Low Blood Pressure	Frequently Tired	Respiratory Problems
Epilepsy/Convulsions	Anemia	Mitral Valve Prolapse
Leukemia	Joint Replacement or implant	Thyroid Problem
Diabetes	Hepatitis/Jaundice	Stroke
Kidney Diseases	Sexually transmitted disease	Orthodontic Treatment
AIDS or HIV infection	Easily Winded	Clench or grind teeth
Sensitive Teeth	Sores or Lumps in Mouth	Prolonged bleeding after extractions
Head Neck or Jaw injury	Frequent Headaches	Jaw, clicking, difficulty opening, closing or chewing

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 my 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 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 pay the $50.00 missed appointment/no show fee should I fail to provide notice of cancellation 24-hours in advance of scheduled appointments. I will be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient/parent/guardian X_____