Patient Medical History

Physician: _____ Office Phone: _____ Date of last exam: _____

Please Circle

1. Are you under any medical treatment now? . . . . . Yes or No
2. Have you ever been hospitalized for any surgical operation or serious illness within last 5 yrs? . . Yes or No
   If yes please explain:
3. Are you taking any medication (s) including non-prescription medicine? . . . . . Yes or No
   If yes, please list you medication(s):
4. Do you use tobacco? . . . . . Yes or No
5. Have you ever taken phen phen? . . . . . Yes or No
6. Do you use controlled substances? . . . . . Yes or No
7. Are you wearing contact lenses? . . . . . Yes or No
8. Do you have or had any of the following:

Please Circle

High blood Pressure	Y N	Low Blood Pressure	Y N	Chest Pain	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Heart Disease	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Heart Trouble	Y N	Angina	Y N	Mitral Valve Prolapse	Y N
Fainting/Seizures	✔ N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anemia	Y N	Radiation Therapy	Y N
Easily Winded	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy/Convulsions	Y N	Cancer	Y N	Recent Weight Lost	Y N
Leukemia	Y N	Arthritis	Y N	Respiratory problems	Y N
Diabetes	Y N	Joint replacement/implant	Y N	Swollen Ankles	Y N
Kidney Disease	Y N	Hepatitis / Jaundice	Y N	Liver Disease	Y N
AIDS or HIV infection	Y N	Sexually transmitted Disease	Y N	Hay Fever/Allergies	Y N
Thyroid problem	Y N	Stomach troubles/ulcer	Y N	Other: _____	
Hyper / Hypo	Y N			_____	

9. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	Y N	Barbiturates	Y N	Aspirin	Y N
Penicillin or any other antibiotics	Y N	Sedatives	Y N	Any metals	Y N
Sulfa Drugs	Y N	Iodine	Y N	Latex Rubber /Powder	Y N
Other: _____					

10. Women ONLY:
    a) Are you pregnant or think you May be pregnant? Y N
    b) Are you Nursing? Y N
    c) Are you taking any oral Contraceptives? Y N

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 diagnosis and the records to any treatment or examination rendered to my child or me during the period of such dental care to third party payers 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 then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____
Signature of Patient / Parent / Guardian

My dental treatment and possible alternative have been discussed with me. I have been informed of all risks involved with my dental care and local anesthesia, including possible blood loss and infection. I hereby consent to the administration of local anesthesia and the dental treatment by the diagnosing doctor.

_____
Signature of Doctor

_____
Signature of Patient / Parent / Guardian

_____
Date

_____
Date