ID: Chart ID:

MEDICAL HISTORY

Patient Name: Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○Yes ○No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ○Yes ○No If yes, please explain:_____

Have you ever had a serious head or neck injury? ○Yes ○No If yes, please explain:_____

Are you taking any medications, pills, or drugs? ○Yes ○No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No *Are any of these medications a blood thinner?___

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No *Daily Aspirin Regimen?___

Are you on a special diet? ○Yes ○No

Do you use tobacco? ○Yes ○No

Do you use controlled substances? ○Yes ○No

Do you have sleep apnea? ○Yes ○No

Do you wear a C-Pap machine? ○Yes ○No

Have you ever had a sleep study done? ○Yes ○No

Women: Are you

Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Local Anesthetics ○Acrylic ○Metal ○Latex ○Sulfa Drugs

○Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○Yes ○No	Cortisone Medicine ○Yes ○No	Hemophilia ○Yes ○No	Radiation Treatments ○Yes ○No
Alzheimer's Disease ○Yes ○No	Diabetes ○Yes ○No	Hepatitis A ○Yes ○No	Recent Weight Loss ○Yes ○No
Anaphylaxis ○Yes ○No	Drug Addiction ○Yes ○No	Hepatitis B or C ○Yes ○No	Renal Dialysis ○Yes ○No
Anemia ○Yes ○No	Easily Winded ○Yes ○No	Herpes ○Yes ○No	Rheumatic Fever ○Yes ○No
Angina ○Yes ○No	Emphysema ○Yes ○No	High Blood Pressure ○Yes ○No	Rheumatism ○Yes ○No
Arthritis/Gout ○Yes ○No	Epilepsy or Seizures ○Yes ○No	High Cholesterol ○Yes ○No	Scarlet Fever ○Yes ○No
Artificial Heart Valve ○Yes ○No	Excessive Bleeding ○Yes ○No	Hives or Rash ○Yes ○No	Shingles ○Yes ○No
Artificial Joint ○Yes ○No	Excessive Thirst ○Yes ○No	Hypoglycemia ○Yes ○No	Sickle Cell Disease ○Yes ○No
Asthma ○Yes ○No	Fainting Spells/Dizziness ○Yes ○No	Irregular Heartbeat ○Yes ○No	Sinus Trouble ○Yes ○No
Blood Disease ○Yes ○No	Frequent Cough ○Yes ○No	Kidney Problems ○Yes ○No	Spina Bifida ○Yes ○No
Blood Transfusion ○Yes ○No	Frequent Diarrhea ○Yes ○No	Leukemia ○Yes ○No	Stomach/Intestinal Disease ○Yes ○No
Breathing Problem ○Yes ○No	Frequent Headaches ○Yes ○No	Liver Disease ○Yes ○No	Stroke ○Yes ○No
Bruise Easily ○Yes ○No	Genital Herpes ○Yes ○No	Low Blood Pressure ○Yes ○No	Swelling of Limbs ○Yes ○No
Cancer ○Yes ○No	Glaucoma ○Yes ○No	Lung Disease ○Yes ○No	Thyroid Disease ○Yes ○No
Chemotherapy ○Yes ○No	Hay Fever ○Yes ○No	Mitral Valve Prolapse ○Yes ○No	Tonsillitis ○Yes ○No
Chest Pains ○Yes ○No	Heart Attack/Failure ○Yes ○No	Osteoporosis ○Yes ○No	Tuberculosis ○Yes ○No
Cold Sores/Fever Blisters ○Yes ○No	Heart Murmur ○Yes ○No	Pain in Jaw Joints ○Yes ○No	Tumors or Growths ○Yes ○No
Congenital Heart Disorder ○Yes ○No	Heart Pacemaker ○Yes ○No	Parathyroid Disease ○Yes ○No	Ulcers ○Yes ○No
Convulsions ○Yes ○No	Heart Trouble/Disease ○Yes ○No	Psychiatric Care ○Yes ○No	Venerial Disease ○Yes ○No
Have you ever had any serious ilness not listed above? ○Yes ○No _____			Yellow Jaundice ○Yes ○No

Comments _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fee incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (Parent of Child) _____ Date _____ Doctor Initials _____