YOUR MEDICAL HEALTH

Name of physician ______________________ Phone Number ______________

Have you been under a physician's care during the past 2 years? ❐ Yes ❐ No

Have you been treated in a hospital in the past 2 years? ❐ Yes ❐ No Explain: ______________

List any major surgeries______________________

If female: Are you taking hormones or birth control? ❐ Yes ❐ No

Are you pregnant or nursing? ❐ Yes ❐ No

Have you had canker or cold sores on your lips, tongue, gums or body? ❐ Yes ❐ No

Have you been treated for/been told you have heart disease? ❐ Yes ❐ No

Have you lost or gained more than 10 pounds in the past year? ❐ Yes ❐ No

Do you smoke ❐ Yes ❐ No chew tobacco? ❐ Yes ❐ No How Long? ______________

Medications you are presently taking? ❐ Blood Thinner ❐ Cortisone Drugs ❐ Sedatives

Others ______________________

Are you allergic to: ❐ Aspirin ❐ Acrylic ❐ Codeine ❐ Latex ❐ Penicillin ❐ Household Bleach ❐ Local Anesthetics Other ______________

Have you had or do you now have:

	Yes	No		Yes	No		Yes	No
High blood pressure	❐	❐	Diabetes	❐	❐	Organ transplant	❐	❐
Low blood pressure	❐	❐	Drug dependency	❐	❐	Pacemaker	❐	❐
AIDS	❐	❐	Emphysema	❐	❐	Prolonged bleeding	❐	❐
Alcohol Abuse	❐	❐	Epilepsy	❐	❐	Prolonged cough	❐	❐
Allergies	❐	❐	Fainting	❐	❐	Psychiactric treatment	❐	❐
Anemia	❐	❐	Glaucoma	❐	❐	Radiation therapy	❐	❐
Arthritis	❐	❐	HIV Positive	❐	❐	Rheumatic fever	❐	❐
Artificial heart valves	❐	❐	Heart murmur	❐	❐	Sickle cell anemia	❐	❐
Artificial joints	❐	❐	Hepatitis Type ______	❐	❐	Sinus trouble	❐	❐
Asthma	❐	❐	Herpes	❐	❐	Sleep Apnea	❐	❐
Cancer	❐	❐	Jaundice	❐	❐	Stroke	❐	❐
Chemotherapy	❐	❐	Kidney disease	❐	❐	Swollen ankles	❐	❐
Chest Pain	❐	❐	Liver disease	❐	❐	Tuberculosis	❐	❐
Congenital heart lesions	❐	❐	Mitral valve prolaspe	❐	❐	Thyroid disease	❐	❐
Cortisone medicine	❐	❐	Neurological disorder	❐	❐	Ulcers	❐	❐
Cosmetic surgery	❐	❐				Venereal disease	❐	❐

Have you taken IV/IM bisphosphonates yes ❐ no ❐

Have you had any disease, condition, or problem not previously listed? ______________

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I authorize the Doctor and staff to take needed x-rays and perform diagnostic procedures and examinations as deemed necessary by the Doctor to make a thorough diagnosis of my (or my child's) dental needs.

I understand I will be given the opportunity and am encouraged to ask any questions I might have concerning my (or my child's) dental condition, contemplated or alternative treatment, procedures and associated risks.

After having my questions answered I authorize the Doctor and staff to perform mutually agreed upon treatment and procedures and use medications and anesthetic agents as may be necessary for proper dental care. I understand that any medications used including anesthetic agents embodies some risk. I further understand that unforeseen conditions can arise during the course of treatment which may call for procedures in addition to, or different from, those originally contemplated and I will be informed, whenever possible, prior to these additional or changed procedures.

I agree to be responsible for payment for dental services provided in this office for myself (or my child), due and payable at the time services are rendered unless specific financial arrangements have been made prior to treatment.

I certify that I have read the above information.

Patient's or Guardian's Signature ______________________ *Date*______________