Patient's Name________________________________

Chart #______________________________

MEDICAL HISTORY

Write the answer to each question in the space provided. If the question is not understood, you are not sure, or you have a question, please indicate so in the space and discuss with the doctor.

Answer all question s. Incorrect or missing information can be dangerous to your health.

Name of Medical Doctor ______________________________ Phone ______________

Address ____

Date of Last Medical Visit______________________ Reason ______________________

Person to contact in emergency ______________________________ Phone ______________

1. Are you currently under the care of a physician?________ If yes, for what reason? ______________________

   ____

2. Are you currently taking any medication? __________ (Include over-the-counter medications, birth control, etc). If so, what?

   medications and for what reasons?______________________________

3. Have you ever had or been treated for:

   Rheumatic fever, heart murmur, congenital heart disease, or mitral valve prolapse? ______________________

   Heart trouble, heart attack, angina, pacemaker, irregular beat? ______________________

   Abnormal blood pressure (hypertension)? ______________________

   Stroke? ______________________

   Blood disorder such as anemia? ______________________

   Excessive bleeding after a cut or extraction? ______________________

   Diabetes?______________________

   Cancer? ______________________

   Breathing problems, asthma, hayfever? ______________________

   Sinus trouble?______________________

   Tuberculosis?______________________

   Hepatitis, jaundice or liver disease? ______________________

   Kidney problems? ______________________

   Thyroid or Goiter problems? ______________________

   Glaucoma? ______________________

(Over)

Medical History (Continued)

Fainting spells, epilepsy or seizures? ____________

Ulcers? ____________

Sexually Transmitted Disease? ____________

AIDS or immunosuppresive disorders? ____________

Arthritis or rheumatism? ____________

4. Do you smoke or use tobacco? ______ How Much? ____________

5. Do you clench or grind your teeth? ____________

6. Do you have frequent or severe headaches? ____________

7. Are you allergic to or have you reacted adversely to:
   Local anesthetics? ____________
   Penicillin? ____________
   Other antibiotics? ____________
   Sulfa drugs? ____________
   Codeine? ____________
   Aspirin? ____________
   Iodine? ____________

8. Do you have any disease, condition, or problem not listed above that you think we should know about? ______ If so explain. ____________

9. Have you had any serious trouble associated with previous dental treatment? ____________

____

10. For women: Are you pregnant? ______ If yes, due date? ____________

I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if any change occurs in my health I an to report it to the dental office. I have read and understood each question.

I authorize the dentist(s) treating me to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I assign you all dental insurance payments that I an entitled to for work performed by you to the extent permitted under my dental insurance policies, if any, and agree to pay any claims not paid within 45 days.

Services are rendered to you, the patient. Responsibility for payment to this office is with you, the patient, not the insurance company. If the insurance company fails to pay within 45 days, the payment is immediately due from you. Our office will assist you in submitting your claim, but cannot accept the responsibility for collecting your insurance claim or negotiating reimbursement schedules.

Person completing the form: Signature ____________

Print name: ____________ Date: ____________

If other than patient, please indicate relationship: ____________

Dr. Signature: ____________