Name: _____

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name _____

   Address _____ Phone # _____
6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____
8. Are you aware of being allergic to or have you ever reacted adversely to any medication of substance? ..... YES NO
9. Indicate which of the follow you have had or have at present. Circle "yes" or "no" to each item. ..... YES NO

   If yes, please list: _____

Heart Failure	YES	NO	Emphysema	YES	NO	Hepatitis A (infectious)	YES	NO
Hearth Disease or Attack	YES	NO	Cough	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Tuberculosis (TB)	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Yellow Jaundice	YES	NO
Heart Murmur	YES	NO	Hay Fever	YES	NO	Blood Transfusion	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Drug Addiction	YES	NO
congenital Heart Lesions	YES	NO	Allergies or Hives	YES	NO	Hemophilia	YES	NO
Scarlet Fever	YES	NO	Diabetes	YES	NO	Venereal Disease		
Artificial Heart Valve	YES	NO	Thyroid Disease	YES	NO	(Syphilis, Gonorrhea)	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Cold Sores	YES	NO
Heart Surgery	YES	NO	Chemotherapy (Cancer, Leukemia)	YES	NO	Fever Blisters	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Arthritis	YES	NO	Epilepsy or Seizures	YES	NO
Anemia	YES	NO	Rheumatism	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Cortisone Medicine	YES	NO	Nervousness	YES	NO
Kidney Trouble	YES	NO	Glaucoma	YES	NO	Psychiatric Treatment	YES	NO
Ulcers	YES	NO	Pain in Jaw Joints	YES	NO	Sickle Cell Disease	YES	NO
Cosmetic Surgery	YES	NO	A.I.D.S.	YES	NO	Bruise Easily	YES	NO

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than two pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition, or problems not listed? ..... YES NO

For Women Only:

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____ Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

The undersigned hereby authorizes 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 in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. There is a charge for non-sufficient fund checks of $25.00. If I fail to give 24 hour notice of cancellation, I consent to being billed for that appointment at the rate of $35.00 per half hour.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____