Medical History

Name_____ Date_____

1. Physician's Name_____ Phone #_____

   Address_____

2. Are you currently under physician's care? If yes, for what reason?_____ Yes No
3. Have you been hospitalized in the last 2 years? If yes, for what reason?_____ Yes No
4. Have you ever taken Fen-Phen / Redux?_____ Yes No
5. Are you sensitive or allergic to dental anesthetic or Latex? If yes, please specify:_____ Yes No
6. Please list your current medications:

   _____

   _____

7. Please list your drug allergies:

   _____

   _____

8. Do you have or have ever had any of the following?

High Blood Pressure_____ Yes No	Allergies or Hives_____ Yes No	Hepatitis_____ Yes No
Angina Pectoris_____ Yes No	Sinus Problems_____ Yes No	Venereal Disease_____ Yes No
Stroke_____ Yes No	Asthma_____ Yes No	A.I.D.S. or H.I.V. Positive_____ Yes No
Heart Disease_____ Yes No	Emphysema_____ Yes No	Blood Transfusion_____ Yes No
Heart Attack_____ Yes No	Tuberculosis_____ Yes No	Hemophilia_____ Yes No
Heart Surgery_____ Yes No	Diabetes_____ Yes No	Anemia_____ Yes No
Heart Pacemaker_____ Yes No	Thyroid Problems_____ Yes No	Sickle Cell Disease_____ Yes No
Artificial Heart Valve_____ Yes No	Kidney Disease_____ Yes No	Bruise Easily_____ Yes No
Mitral Valve Prolapse_____ Yes No	Ulcers_____ Yes No	Liver Disease_____ Yes No
Heart Murmur_____ Yes No	Cancer or Tumor_____ Yes No	Yellow Jaundice_____ Yes No
Rheumatic Fever_____ Yes No	Radiation or Chemotherapy_____ Yes No	Cold Sores or Fever Blisters_____ Yes No
Artificial Joints_____ Yes No	Epilepsy or Seizures_____ Yes No	Cortisone Medication_____ Yes No
Arthritis or Rheumatism_____ Yes No	Fainting or Dizzy Spells_____ Yes No	Drug Addiction_____ Yes No
Osteoporosis_____ Yes No	Nervousness_____ Yes No	Cigarettes_____ Yes No

9. Do you have or have you had any disease, condition or problem not listed?_____ Yes No

   If yes, please list:_____

10. WOMEN ONLY: Are you pregnant?__Yes No / What Month?___ / Nursing?___Yes No / Are you taking birth control pills? ___Yes No

I understand the above information is accurate to the best of my knowledge and is necessary to provide me with dental care in a safe and efficient manner. I will inform the doctor of any change in my medical status.

I authorize the doctor to perform recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated by such treatment.

I authorize my insurance company to pay the dentist all benefits otherwise payable to me for services rendered. I authorize the use of my social security number and my signature on my dental insurance claims.

I understand payment is due in full at time of treatment unless prior arrangements have been approved.

Patient Signature_____ Date_____

Medical History Updates

Date	Please note any changes since you last filled out this form	Patient Signature	Doctor Review