

MEDICAL HISTORY

I consider my health to be: Excellent Good Fair Poor

Physician's Name: _____

Date of Last Visit: _____

Please check off if you have ever had a history of any of the following conditions:

- | | | | |
|--|---|--|---|
| <input type="radio"/> Abnormal Bleeding | <input type="radio"/> Cortisone Medication | <input type="radio"/> Heart Surgery | <input type="radio"/> Epilepsy/Seizures |
| <input type="radio"/> Anemia | <input type="radio"/> Pain in jaw joints/TMJ | <input type="radio"/> Heart Attack | <input type="radio"/> Psychiatric Treatment |
| <input type="radio"/> Artificial bones/joints/valves | <input type="radio"/> Blood Transfusion | <input type="radio"/> Kidney Trouble | <input type="radio"/> Emphysema |
| <input type="radio"/> Angina/Chest Pain | <input type="radio"/> Lupus | <input type="radio"/> Shortness of breath | <input type="radio"/> Jaundice |
| <input type="radio"/> Heart Disease | <input type="radio"/> Fainting/Dizzy Spells | <input type="radio"/> Radiation/Chemotherapy | <input type="radio"/> HIV/AIDS |
| <input type="radio"/> Stroke | <input type="radio"/> Sickle Cell Disease | <input type="radio"/> Asthma | |
| <input type="radio"/> Ulcers | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Trouble | WOMEN |
| <input type="radio"/> Tumor/Cancer | <input type="radio"/> Drug Abuse / Alcoholism | <input type="radio"/> Diabetes | Are you taking birth control medication? <input type="radio"/> Yes <input type="radio"/> No |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Persistent Cough | <input type="radio"/> Arthritis/Rheumatism | Are you pregnant or nursing? <input type="radio"/> Yes <input type="radio"/> No |
| <input type="radio"/> Hay Fever | <input type="radio"/> Hemophilia | <input type="radio"/> Glaucoma | |
| <input type="radio"/> Hives | <input type="radio"/> Hepatitis Type _____ | <input type="radio"/> Bruise Easily | |
| <input type="radio"/> Thyroid Disease | <input type="radio"/> High/Low Blood Pressure | <input type="radio"/> STD/Venereal Disease | |

Please list if you have a condition/disease not referenced:

Please list any hospitalizations:

Please list all medications you are currently taking:

Please check off all allergies that apply:

- | | |
|---------------------------------------|--|
| <input type="radio"/> Aspirin | <input type="radio"/> Local Anesthetic |
| <input type="radio"/> Penicillin | <input type="radio"/> Erythromycin |
| <input type="radio"/> Codeine | <input type="radio"/> Tetracycline |
| <input type="radio"/> Metals/plastics | <input type="radio"/> Latex |

Please list any other drugs/materials that you are allergic to:

Please add anything to this history you feel is important:

In the event of an emergency, who should we contact?

Name: _____ Relation: _____

Phone Number: _____

TERMS AND CONDITIONS

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date

Relation (if other than patient)

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I have read the above conditions and agree to their content.

Signature

Date

Relation (if other than patient)

Medical History reviewed by: _____ Date: _____