MEDICAL HISTORY

Patient name ______________________________________ Date of Birth____________________
(please print name)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name______________________________ Phone #__________________________________

Are you under a physician's care now? Yes No If yes, please explain______________________________

Do you use tobacco? Yes No If yes, Smoke or chew______________________________

Do you use controlled substances? Yes No If yes, please explain______________________________

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin or other antibiotics Codeine Acrylic (artificial nails) Metals Latex Local Anesthetics Milk

Other – Please explain ____

Are you taking any medications, over-the-counter drugs, herbal medications, or vitamins? If yes, please list:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Do you have, or have you had, any of the following? (Please circle the ones that apply)

Acid Reflux	Blood Transfusion	Glaucoma	Pain in Jaw Joints
AIDS/HIV	Cancer/Leukemia	Heart Pace Maker	Radiation Treatments
Alzheimer's Disease	Chemotherapy	Heart Trouble/disease	Renal Dialysis
Anemia	Diabetes	Hepatitis A, B, or C	Rheumatic Fever
Angina	Drug Addiction	High Blood Pressure	Sinus Trouble
Arthritis/Gout	Epilepsy or seizures	Liver Disease	Stroke
Artificial Heart Valve	Excessive Bleeding	Low Blood Pressure	Thyroid Disease
Artificial Joint	Frequent Headaches	Lung Disease	Tuberculosis
Asthma	Genital Herpes	Mitral Valve Prolapse	Venereal Disease

Have you ever had any serious illness not listed above? If yes, please explain______________________________

Whom may we call in case of an emergency?______________________________ Phone____________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I hereby give consent for treatment and the use of such anesthetic or the taking of x-rays or radiographs which may be deemed advisable by the Doctor.

I authorize this office to send any necessary x-rays or explanation of treatment to my insurance company.

I understand that any balance due is my responsibility to pay.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN______________________________ DATE ____________________

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