

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO		YES	NO	
Are you under Medical Treatment Now?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to or have you had any reactions to the following:			
Have you ever been hospitalized for any surgical operation or serious illness in the past 5 years? If yes, please explain	<input type="checkbox"/>	<input type="checkbox"/>		Local Anesthetics (eg. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
_____				Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
_____				Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?	<input type="checkbox"/>	<input type="checkbox"/>		Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
_____				Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
_____				Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>		Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>		Any Metals (eg. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
_____				Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
_____			Other _____	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If yes, what medication(s) are you taking?			Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
_____				<input type="checkbox"/>	<input type="checkbox"/>	

Women: are you...

Pregnant or think you may be pregnant? nursing? taking oral contraceptives?

Do you have, or have you had, any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/			Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/			Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths	<input type="checkbox"/>	<input type="checkbox"/>
Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
_____			Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any serious illness not listed above?				<input type="checkbox"/>	<input type="checkbox"/>	If yes _____					
Dental Concerns / Comments				<input type="checkbox"/>	<input type="checkbox"/>	If yes _____					

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request

my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor)

Doctor's Comments

Signature _____ Date _____