MEDICAL HISTORY

Physician's Name____ Date of last visit___________

Please circle YES or NO to indicate if you have had any of the following:

AIDS	YES NO	Hepatitis	YES NO	Psychiatric care	YES NO
Anemia	YES NO	Type______________		Radiation treatment	YES NO
Arthritis	YES NO	Herpes	YES NO	Respiratory disease	YES NO
Artificial heart valves	YES NO	High blood pressure	YES NO	Rheumatic fever	YES NO
Asthma	YES NO	meds___________________		Scarlet fever	YES NO
Bleeding abnormally	YES NO	HIV positive	YES NO	Sinus trouble	YES NO
Blood disease	YES NO	Joint replacement	YES NO	Stroke	YES NO
Chemical dependency	YES NO	Kidney disease	YES NO	Thyroid disease	YES NO
Chemotherapy	YES NO	Low blood pressure	YES NO	Tonsillitis	YES NO
Circulation problems	YES NO	Mitral valve prolapse	YES NO	Tumors of head or neck	YES NO
Cough, persistent/bloody	YES NO	Nervous problems	YES NO	Ulcers	YES NO
Diabetes	YES NO	Pacemaker	YES NO	Venereal disease	YES NO
Do you wear contacts	YES NO	Women:		Weight loss/unexplained	YES NO
Epilepsy	YES NO	Are you pregnant?	YES NO	Any Hospital Stays	YES NO
Fainting/dizziness	YES NO	Due date______________		Explain___________________	
Glaucoma	YES NO	Are you nursing?	YES NO	__________________________	
Headaches	YES NO	Are you taking birth control		__________________________	
Heart problems	YES NO	pills?	YES NO	__________________________	

MEDICATIONS

Please list medication you are currently taking:

____

____

____

Pharmacy name_______________________

Phone number _______________________

ALLERGIES

Aspirin	YES NO	local anesthetic	YES NO
barbiturates	YES NO	penicillin	YES NO
codeine	YES NO	sulfa	YES NO
latex	YES NO	other_____________	
iodine	YES NO	_________________	
		_________________	

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an Agreement between me and my insurance company.

I understand that I may be charged a 1.5% finance charge per month (18%) annually if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permissions for my dentist and dental team to use my photographs for in-office education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

____ date________________________

PATIENT SIGNATURE

____ date ________________________

DOCTOR'S SIGNATURE

(I have read, agreed to and understand the statement listed above.)