**Name:** _____

# Medical History

**Physician's Name** _____Phone (  ) _____

When was your last physical exam? _____

Are you taking any medications? Please List_____

Do you have any allergies to medications? ☐Yes ☐No If yes, what? _____

Have you been a patient in a hospital in the past five years? ☐Yes ☐No Please Explain _____

Have you ever had any surgeries? ☐Yes ☐No Please List _____

Have you ever had healing complications? ☐Yes ☐No

Do you take Viagra, Cialis, Levitra? ☐Yes ☐No

Have you ever taken bone density enhancement medications to prevent osteoporosis? (i.e. Fosomax/Aredia/Bonevia) ☐Yes ☐No

**Have you had or do you have any of the following:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | ☐Yes | ☐No | Substance Abuse (Alcohol, Drugs) | ☐Yes | ☐No |
| Heart Pacemaker/ Defibrillator | ☐Yes | ☐No | Ulcers | ☐Yes | ☐No |
| High Blood Pressure | ☐Yes | ☐No | Thyroid Problems | ☐Yes | ☐No |
| Artificial Heart Valve | ☐Yes | ☐No | Tuberculosis | ☐Yes | ☐No |
| Stroke/ TIA | ☐Yes | ☐No | Diabetes | ☐Yes | ☐No |
| Heart Murmur (MVP)/ Rheumatic Fever | ☐Yes | ☐No | Glaucoma | ☐Yes | ☐No |
| Artificial Joints (hip, knee etc.) | ☐Yes | ☐No | Asthma | ☐Yes | ☐No |
| Arthritis/Rheumatism or swelling of joints | ☐Yes | ☐No | Latex Sensitivity | ☐Yes | ☐No |
| Kidney Disease | ☐Yes | ☐No | Allergies or Hives | ☐Yes | ☐No |
| Pain in Jaw Joints | ☐Yes | ☐No | Sinus Trouble | ☐Yes | ☐No |
| Sexually Transmitted Disease (Venereal) | ☐Yes | ☐No | Radiation Therapy, Chemotherapy | ☐Yes | ☐No |
| Cold Sores/Fever Blisters | ☐Yes | ☐No | Cancer, Tumor | ☐Yes | ☐No |
| Blood Transfusion | ☐Yes | ☐No | Fainting or Dizzy Spells | ☐Yes | ☐No |
| Anemia | ☐Yes | ☐No | Epilepsy or Seizures | ☐Yes | ☐No |
| Hemophilia, Bleeding problems | ☐Yes | ☐No | Psychiatric/Psychological Care | ☐Yes | ☐No |
| Liver Disease | ☐Yes | ☐No | AIDS, ARC, HIV Positive | ☐Yes | ☐No |
| Hepatitis A, B, or C | ☐Yes | ☐No | Cosmetic Surgery | ☐Yes | ☐No |

**For Women Only:** Are you pregnant? ☐Yes ☐No If yes, Due date? _____

Are you taking birth control pills? ☐Yes ☐No

Do you have or have you had any disease, condition or problem not listed? ☐Yes ☐No

Please explain: _____

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any change in my health or medication.*

# Consent for Treatment

**1.** I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

**2.** Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon myself and to employ such assistance as required to provide proper care.

**3.** I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature _____ Date_____

Witness_____