

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