MEDICAL HISTORY

Do you have a personal physician? Yes ____ No ____

Their Name: _____

Their Phone #: _____

The approximate date of your last visit: _____

Your current physical health is:
Good _____ Fair _____ Poor _____

Are you currently under the care of any physician or dentist?
Yes _____ No _____ If so, please explain: _____

Do you smoke or use tobacco in any other form? Yes ___ No ___

Are you presently taking any drugs prescribed by a physician or dentist? Yes ____ No ____ If yes, please list: _____

_____

For women: Are you pregnant? No ___ Yes ___ Wk# _____

Do you need to be premedicated with an antibiotic before medical treament?
Yes ____ No ____

Have you had cosmetic enhancements?
Yes ____ No ____

Have you ever had any of these diseases or medical problems?

Y	N		Y	N	
☐	☐	AIDS / HIV Positive	☐	☐	High Blood Pressure
☐	☐	Alzheimer's Disease	☐	☐	High Cholesterol
☐	☐	Parkinsons	☐	☐	Irregular Heart Beat
☐	☐	Artificial Heart Valve	☐	☐	Latex Allergies
☐	☐	Artificial Joints	☐	☐	Low Blood Pressure
☐	☐	Blood Transfusion	☐	☐	Mitral Valve Prolapse
☐	☐	Cancer	☐	☐	Osteoporosis
☐	☐	Chemotherapy	☐	☐	Pain in Jaw Joints
☐	☐	Cold Sores/Fever Blisters	☐	☐	Psychiatric Care
☐	☐	Diabetes	☐	☐	Radiation Treatments
☐	☐	Drug Addiction	☐	☐	Sinus Trouble
☐	☐	Excessive Thirst	☐	☐	Sleep Apnea
☐	☐	Heart Attack /Failure	☐	☐	Stomach/Intestinal Disease
☐	☐	Heart Murmur			
☐	☐	Heart Pacemaker	☐	☐	Acid Reflux
☐	☐	Heart Trouble/Disease	☐	☐	Taken Bisphosphonates
☐	☐	Hemophilia	☐	☐	Thyroid Problems
☐	☐	Hepatitis A	☐	☐	Tuberculosis
☐	☐	Hepatitis B or C	☐	☐	Neck/Back Pain
			☐	☐	Dry Mouth/Sjogrens

Any other serious medical conditions:
Have you experienced any that are not listed above?
Yes ____ No ____ If yes, please list: _____

_____

Are you allergic to or have you ever reacted adversely to any medication or substance? Yes ___ No ___
if yes, please list: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also under-stand that this information will be held in the strictest confidence and it is my resposibility to inform this office of any changes in my medical status.

_____ _____
Signature **Date**

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photograph, and any other diagnotic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)

_____'s dental needs

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agree upon by me 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.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 30 days, I understand that a 1 ½% late charge (18% APR) my be added to my account. In the event my account becomes delinquent 60 days, I understand that a billing charge of $3.00 may be added to my account.

Patient: _____ Date: _____

Witness: _____

Parent or Responsible Party: _____

Relationship to Patient: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA and the ADA.