

MEDICAL HISTORY

Patient Name: _____ Date: _____

Physicians Name: _____ Phone Number: _____

1. Are you currently under the care of a physician? Please circle Yes or No

Please explain: _____

2. Are you allergic to any of the following: Y / N Dental Anesthetics Y / N Aspirin Y / N Erythromycin

Y / N Tetracycline Y / N Latex Y / N Codeine Y / N Penicillin

3. Do you have any other allergies? _____

Please circle Y or N and specific item as it applies to you

Y/N Heart attack, Heart trouble, Heart surgery _____

Y/N Angina _____

Y/N High Blood Pressure _____

Y/N Prolapsed Mitral Valve/Heart Murmur _____

Y/N Artificial Heart Valve _____

Y/N Heart condition you were born with _____

Y/N Pace Maker or defibrillator _____

Y/N Rheumatic Fever or Scarlet Fever _____

Y/N Blood Disease/Transfusion _____

Y/N Excessive Bleeding or hemophilia _____

Y/N Anemia/Easy Bruising _____

Y/N Stroke _____

Y/N Allergies/Hives/Skin Rash/Latex Allergy _____

Y/N Asthma/Persistent Cough/Sinus Problems _____

Y/N Tuberculosis/Emphysema _____

Y/N Cancer Treatment/Radiation Therapy _____

Y/N Ulcers/Gastritis/Colitis/Hernia _____

Y/N Artificial Joints anywhere in your body _____

Y/N Arthritis _____

Y/N Venereal Disease _____

Y/N AIDS/HIV infection _____

Y/N Liver Disease/Hepatitis _____

Y/N Shingles/Herpes/Fever Blisters _____

Y/N Glaucoma/Eye Surgeries _____

Y/N Epilepsy/Seizures/Fainting spells _____

Y/N Psychiatric Care _____

Y/N Kidney Trouble _____

Y/N Substance Abuse _____

Y/N Diabetes _____

5. Have you taken Fen-Phen or any other weight loss drug? Yes or No Which ones? _____

6. Have you ever had any complications following dental treatment? Yes or No If yes please explain _____

7. Have you been admitted to a hospital or needed emergency care during the past two years? _____

8. Please list any past surgery: _____

9. Please list your medications: _____

10. Is there anything else we should know about your health? _____

Women only:

Y / N Currently pregnant Y / N Nursing Y / N Female problems
Week #: _____ Are you taking birth control pills? _____

*****SEVERAL STUDIES HAVE SHOWN THAT TAKING THE FOLLOWING MEDICATIONS MAY REDUCE THE EFFECTIVENESS OF YOUR BIRTH CONTROL PILLS: ANTIBIOTICS - SULFA DRUGS – PAIN KILLERS – TRANQUILIZERS – SEDATIVES – ANTIHISTAMINES.**

CONSENT FOR SERVICES

To the best of my knowledge, all of the preceding answers and information provide are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis. I consent to the taking of photographs and x-rays before, during, and after treatment, as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for these photographs, x-rays and records to be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phonebooks, television), and publication in professional journals. I further understand that if the photographs, x-rays, and records are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I am responsible for payment of all services rendered on my behalf or my dependents.

Sign here to verify: _____
Signature (parent or guardian if patient is a minor)

Date