



Patient name:

Date of Birth:

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question)

- 1 Yes No Is your general health good?
If NO, explain:
- 2 Yes No Has there been a change in your health within the last year? If YES, explain:
- 3 Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain:
- 4 Yes No Are you being treated by a physician now? If YES, explain:
Date of last medical exam: Reason for exam:
- 5 Yes No Have you had problems with prior dental treatment? If YES, explain:
- 6 Yes No Are you in pain now? If YES, explain:

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain (angina) | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Frequent vomiting |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Diarrhea or constipation | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Recent significant weight loss | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint pain or stiffness |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Stomach problems, ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Xheart Defects | <input type="checkbox"/> Family history of diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Tumors or cancer | <input type="checkbox"/> Sexual transmitted disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Radiation | <input type="checkbox"/> Canker or cold sores |
| <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Emphysema or other lung disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Kidney or bladder disease | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Transplants |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Tuberculosis |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please check all that apply)

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Valium | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Demerol | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Percodan |
| <input type="checkbox"/> Local anesthetic (Novacaine, Xylocain) | <input type="checkbox"/> Latex | <input type="checkbox"/> Food |
| <input type="checkbox"/> Nitrous oxide | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metal |

Others:

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please check all that apply)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> Tobacco in any form | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Over-the-counter medicines | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Supplements |
| <input type="checkbox"/> Weight loss medications | <input type="checkbox"/> Bisphosphonate (Fosamax) | <input type="checkbox"/> Aspirin |

VI. WOMEN ONLY

- Yes No
- Yes No
- Yes No

Are you, or could you be, pregnant? If YES, what month?

Are you nursing?

Are you taking birth control pills?

VII. ALL PATIENTS

- Yes No
- Yes No
- Yes No
- Yes No

Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:

Have you ever been pre-medicated for dental treatment?
If YES, why:

Have you ever taken Fen-phen?
If YES, when:

Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: Phone Number:

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health history and / or medication. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% o the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group. Insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care for myself and/or my children. The information on this page and the and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____			
<input type="radio"/> Adult Patient	<input type="radio"/> Father (or Husband)	<input type="radio"/> Mother (or Wife)	<input type="radio"/> Guardian
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
Date	State Driver's License #		

FAIL/CANCELLATIONS

We trust that you will be here for the time you have reserved with us. If you fail or cancel without a 24 hour notice, a fee will be charged to your account.