MEDICAL HISTORY

Patient Name: _____ Birthdate_____

Physician's name:_____Ph. Number_____

Emergency contact person_____ Emergency contact's phone number_____

CIRCLE EITHER YES OR NO TO THE FOLLOWING QUESTIONS

For women only: Are you pregnant or think you might be pregnant: **YES NO**
Are you nursing: **YES NO**
Are you taking Birth Control Pills **YES NO**

Both Men and Woman answer the following questions.
Have you ever taken Fen-Phen/Redux **YES NO**
Have you ever taken FOSAMAX, BONIVA, ACTONEL: **YES NO**
Do you use tobacco, smoking or chewing **YES NO**

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO ANY OF THE FOLLOWING: *CIRCLE IF YES*

LOCAL ANESTHETICS	SULFA	METALS	TYLENOL (Acetaminophen)
PENICILLIN	IODINE	NUT	OTHER-_____
AMOXICILLIN	ASPIRIN	LATEX	

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING: ***CIRCLE IF YES***

Rheumatic Heart Disease	Scarlet Fever	Hay Fever	Back Problems
Rheumatic Fever	Stroke	Hives or Skin Rash	Stomach Ulcer
Heart Murmur	Hepatitis Type_____	Cold Sores	Kidney Troubles
Angina	Other Liver Disease	Fainting	Epilepsy Seizures
Heart Attack (MI)	AIDS	Nervousness	Anemia
Pacemaker	HIV positive	Vertigo	Glaucoma
A-Fib	STD_____	Diabetes	Tumors
Heart Surgery	Lung or Breathing Problems	Hypoglycemia	Mental Health Care
Mitral valve Prolapse	Asthma	Thyroid Problems	Eating Disorders
High Blood Pressure	Sinus Trouble	Osteo-Arthritis	Cortisone Treatment
Low Blood Pressure	Tuberculosis	Rheumatoid Arthritis	

Are you taking any blood thinners? If yes, what kind_____

Joint Replacement: which joint _____ Date of surgery:_____

Cancer, if yes what kind_____ Year diagnosed_____

Cancer Medications_____

Do you require a Pre-Med before appointments?_____

Do you have any other conditions that you feel I should know about? Please explain

List of **MEDICATIONS/PRESCRIPTIONS** here or provide a separate paper we can scan.

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care, to third party payors and/or health providers. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR _____DATE_____