Medical Information

1. Are you having pain or discomfort at this time?..... YES NO
2. Have you been a patient in the hospital during the past two years?..... YES NO
3. Have you been under the care of a medical doctor during the past two years?..... YES NO
   Physician's Name _____ Phone _____
   Address _____
4. Are you taking any medication or drugs?..... YES NO
   If yes, please list: _____
5. Any allergies?..... YES NO
   If yes, please list: _____

6. Indicate which of the following you have had or have at present. Circle yes or no for each item.

Heart Disease or Attack	YES NO	Kidney Trouble	YES NO	Hepatitis B (serum)	YES NO
Heart Murmur	YES NO	Ulcers	YES NO	Venereal Disease	YES NO
High Blood Pressure	YES NO	Diabetes.....Type 1 / Type 2	YES NO	H.I.V. Positive	YES NO
Arteriosclerosis	YES NO	Thyroid Problems	YES NO	Cold Sores/Fever Blisters	YES NO
Mitral Valve Prolapse	YES NO	Glaucoma	YES NO	Blood Transfusion	YES NO
Artificial Heart Valve	YES NO	Cancer	YES NO	Hemophilia	YES NO
Heart Pacemaker	YES NO	Emphysema	YES NO	Anemia	YES NO
Rheumatic Fever	YES NO	Chronic Cough	YES NO	Bruise Easily	YES NO
Arthritis	YES NO	Tuberculosis	YES NO	Liver Disease	YES NO
Rheumatism	YES NO	Asthma	YES NO	Epilepsy or Seizures	YES NO
Cortisone Medicine	YES NO	Hay Fever	YES NO	Fainting or Dizzy Spells	YES NO
Drug Use/Addiction	YES NO	Allergies or Hives	YES NO	Nervousness	YES NO
Stroke	YES NO	Sinus Trouble	YES NO	Tumors	YES NO
Artificial Joints (Hip, knee, etc.)	YES NO	Hepatitis A (infectious)	YES NO		

7. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
   If yes, please list: _____
8. Do you need to take an antibiotic before dental appointments?..... YES NO

FOR WOMEN ONLY:
Are you pregnant? ❑Yes, what month?_____ ❑No Are you nursing? ❑Yes ❑No Are you taking birth control pills? ❑Yes ❑No

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated of such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge (18% APR) may be added to my account, in addition to any collection charge.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
6 I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

IN OFFICE ONLY

I HAVE REVIEWED IN OFFICE A COPY OF THE HIPPA PRIVACY ACT AND THE FACTS ABOUT FILLINGS BOOKLET

Patient Signature _____ Date _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____