PATIENT MEDICAL HISTORY

Medical Physician:_____ Office #:_____ Date of Last Physical: _____

Address: _____
Street City State Zip Code

1. Are you under medical treatment now? ❒ Yes ❒ No
2. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? If yes, please explain ____ ❒ Yes ❒ No
   _____
3. Are you taking any medication(s) including non-prescription medicine? ❒ Yes ❒ No
   If yes, what medication(s) are you taking? (use bottom of page)
   _____
   _____
4. Do you use tobacco? ❒ Yes ❒ No
5. Do you use any illegal drugs? ❒ Yes ❒ No
6. Are you wearing contact lenses? ❒ Yes ❒ No
7. Are you taking any blood thinners? ❒ Yes ❒ No
8. Do you take aspirin daily? ❒ Yes ❒ No

10. Are you allergic to or have any reactions to the following?
- ❒Local Anesthetics (e.g. Novocaine)
- ❒Penicillin
- ❒Other Antibiotic
- ❒Sulfa Drugs
- ❒Barbiturates
- ❒Sedatives
- ❒Iodine
- ❒Codeine
- ❒Any metal (e.g. nickel, mercury, etc.)
- ❒Latex Rubber
- ❒Other (please list) _____

11. Women only:
- ❒ Yes ❒ No Are you pregnant or think you may be?
- ❒ Yes ❒ No Are you nursing?
- ❒ Yes ❒ No Are you taking oral contraceptives?

9. Do you have or have you had any of the following? (mark box if it applies to you)

- ❒ Rheumatic Fever
- ❒ Rheumatic Heart Disease
- ❒ Heart Murmur
- ❒ Mitral Valve Prolapse
- ❒ Artificial Joints or Implant
- ❒ Artificial Heart Valves
- ❒ Organ Transplant
- ❒ Heart Attack
- ❒ Stroke
- ❒ Cardiac Pacemaker
- ❒ Heart Disease/Trouble
- ❒ Angina/Chest Pains
- ❒ Cancer/Radiation Therapy
- ❒ Bleeding/Clotting Disorders
- ❒ Sickle Cell Anemia
- ❒ Leukemia
- ❒ AIDS/HIV Infection
- ❒ Hepatitis/Jaundice What type? _____
- ❒ Liver Disease
- ❒ Diabetes Insulin Dependent Y or N
- ❒ Kidney Disease
- ❒ Low/High Blood Pressure
- ❒ Asthma
- ❒ Tuberculosis
- ❒ Emphysema/COPD
- ❒ Respiratory Disease
- ❒ Epilepsy/Convulsions
- ❒ Sexually Transmitted Disease
  What _____
- ❒ Glaucoma, Wide or Narrow
- ❒ Stomach Trouble/Ulcers
- ❒ Thyroid Disorder
- ❒ Arthritis
- ❒ Other: _____

Your Pharmacy Information

Rx Name: _____
City: _____ State:_____
Phone: ( ) _____
(In case prescriptions need to be phoned in for you.)

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be financially responsible for payments of all services rendered at each appointment on my behalf or my dependents. In the event that my payment is not received within 90 days of its due date, I agree to pay all costs of collection, including, but not limited to reasonable attorney's fees.

X _____
Patient signature and/or financially responsible party (parent/guardian if a minor)

Meds: _____

_____

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