MEDICAL HISTORY

Physician's Name and Phone: _____ **Date of Last Physical:** _____

Have you ever had any of the following? ***(check boxes that apply)*:**

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	1. Heart Problems	☐	☐	11. Respiratory Problems	☐	☐	20. General Allergies	☐	☐	29. Ulcer
☐	☐	2. High Blood Pressure	☐	☐	12. Epilepsy	☐	☐	21. Blood Disease	☐	☐	30. Venereal Disease
☐	☐	3. Low Blood Pressure	☐	☐	13. Headaches	☐	☐	22. Arthritis	☐	☐	31. Hemophilia
☐	☐	4. Circulatory Problems	☐	☐	14. Hepatitis, Jaundice or Liver Disease	☐	☐	23. Special Diet	☐	☐	32. Nervous Problems
☐	☐	5. Heart Murmur	☐	☐	15. Cancer	☐	☐	24. Swollen Neck Glands	☐	☐	33. Excessive Bleeding
☐	☐	6. Radiation Treatment	☐	☐	16. Psychiatric Care	☐	☐	25. Rheumatic Fever	☐	☐	34. Tuberculosis
☐	☐	7. Artificial Heart Valves	☐	☐	17. Allergies to Latex	☐	☐	26. Sinus Problems	☐	☐	35. Alcohol Addiction
☐	☐	8. Artificial Joints	☐	☐	18. Allergies to Anesthetics	☐	☐	27. A.I.D.S.	☐	☐	36. Drug Addiction
☐	☐	9. Back Problems	☐	☐	19. Allergies to Medicines or Drugs	☐	☐	28. Stroke	☐	☐	37. HIV Positive
☐	☐	10. Diabetes							☐	☐	38. Have you taken Fen phen or Redux

_____

_____

_____

_____

_____ Dr. Signature: _____ Date: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

List all medication being taken: 1. _____ For what condition? _____

2. _____ For what condition? _____

3. _____ For what condition? _____

4. _____ For what condition? _____

If the patient is a child: weight: _____ lbs.

Are you under the care of a physician? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No

MEDICAL HISTORY UPDATE: _____ **Date:** _____

Reason for requesting dental care: _____

Informed consent: This is to certify that I, undersigned, authorize Doctor to take radiographs, study models, photographs, or any other diagnostics aids deemed appropriate by Doctor to make a thorough diagnosis of patient's needs. I also authorize Doctor to perform any and all forms of treatment agreed to be necessary or advisable, including use of local anesthetics and medication as indicated, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I understand that as a service to me this dental office will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

Payment is due at the time services are rendered.

X _____ Date: _____

Signed (patient or parent if minor)

ONLY if you have insurance SIGNATURE ON FILE!

So that you do not have to sign an insurance form at each dental visit, this dental office will maintain this *"signature on file"* for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize ant Provider, Insurer or other Organization to release any information reguarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X _____ Date: _____

Signed (patient or parent if minor)

AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment directly to this dental office for services rendered.

X _____ Date: _____

Signed (patient or parent if minor)

The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust.