MEDICAL HISTORY

Name of Physician______________________ Phone Number______________ Date of Last Physical Exam ____/____/____

Has there been any change in your general health within the past year? ☐ Yes ☐ No

If Yes, Please Explain____

Have you had any serious illness, surgery or hospitalization within the last 5 years? ☐ Yes ☐ No

If Yes, Please Explain____

Have you had any abnormal bleeding or clotting problems associated with extractions, surgery or cuts? ______________

Check (✔) if you have or had any of the following:

☐ Heart Murmur	☐ Epilepsy	☐ Emphysema	☐ Chemical Dependency	☐ Cold Sores/Fever Blisters
☐ Pacemaker/Heart Disease	☐ Fainting Spells	☐ Asthma/Hayfever	☐ ADD/Asperger Syndrome	☐ Hepatitis
☐ Mitral Valve Prolapse	☐ Seizures	☐ Arthritis	☐ Allergies	☐ Liver Disease/Jaundice
☐ Rheumatic/Scarlet Fever	☐ Meningitis	☐ Artificial Joints/Pins	☐ Glaucoma	☐ Thyroid Condition
☐ Heart Attack/Surgery	☐ Neuralgia	☐ Shunts	☐ Blood Transfusion	☐ Herpes
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Rapid Weight Gain or Loss	☐ Anemia	☐ HIV/AIDS
☐ Congestive Heart Failure	☐ Persistent Cough	☐ Cancer	☐ Leukemia	☐ Venereal Disease
☐ Tobacco Habit	☐ Stroke	☐ Chemotherapy	☐ Blood Disease	☐ Kidney Disease
☐ Diabetes	☐ Tuberculosis	☐ Radiation Therapy	☐ Cough Up Blood	☐ Nervous Problems
☐ Stomach/Acid Reflux Disorder	☐ Psychiatric Care	☐ High/Low Blood Pressure	☐ Ulcers	☐ Other

If you have checked any of the above, please explain further (list in sucsession): ______________________________

____

____

List any medications you are currently taking, including non-prescription: ______________________________

____

Are you allergic to or have you had a reaction to:

☐ Local Anesthesia ☐ Penicillin or Other Antibiotics ☐ Latex ☐ Sulfa Drugs ☐ Aspirin/Ibuprofen

☐ Codeine or Narcotics ☐ Sedatives or Sleeping Pills Other ______________________

WOMEN: Are you pregnant? ☐ Yes ☐ No Due Date______________ Nursing? ☐ Yes ☐ No

DENTAL HISTORY

Former Dentist______________________ Address ______________________ Phone ____________

Date of Last Dental Visit ______________ Have You Had Full Mouth X-Rays? ☐ Yes ☐ No Date ____________

Have You been informed that you have periodontal disease? ☐ Yes ☐ No When? ____________

I authorize my treatment or treatment of the patient. The information on this form is accurate to the best of my knowledge. I will inform the dentist if there is any change in my medical status. I understand this information will be used by the dentist to help determine appropriate and healthful dental treatment.

I authorize my dental insurance company to pay the dentist all benefits otherwise payable to me for services rendered. I authorize the use of this signature for all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________________ Date ____________________

MEDICAL HISTORY UPDATES

Date	Blood Pressure/Changes	Signature