

MEDICAL HISTORY

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Name _____ Age _____ Birthdate _____ Marital Status _____
 Address _____ City _____ Zip _____ Phone _____
 Patient Employed By _____ E-mail Address _____
 Business Address _____ City _____ Zip _____
 Occupation _____ Business Phone _____
 Name of Spouse _____ Spouse's Occupation _____
 Spouse Employed by _____ Business Phone _____
 Spouse Business Address _____ City _____ Zip _____
 In Case of Emergency Contact: _____ Phone: _____ City _____
 Name of Physician _____ Address _____ City _____
 Reason for this visit _____ Patient Referred By _____
 Dental Insurance Company _____ Social Security # _____

Dental problems are produced by a combination of many complex elements. Though some of the following questions may seem unrelated to your dental condition, they are all associated with proper management of your oral health.

			Yes	No
1.	Are you under a physician's care at present?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you taking any medicine or vitamins now?	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, please specify name(s): (types, amount, frequency) _____			
3.	Have you ever been seriously ill?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have or have you ever had any of the following? (Date if Applicable)	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
		Yes No		
	Rheumatic fever <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetes (sugar disease) <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Trouble <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hepatitis, jaundice, or liver disease <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Venereal disease <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Leukemia <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cancer <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Are you taking Blood Thinners (Such as Aspirin) <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Respiratory disorder (Tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>
	AIDS/Immuno Depressed/or HIV Positive.	<input type="checkbox"/>	<input type="checkbox"/>
	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
	High or Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
	Any artificial heartvalve, hip or knee, replacement, etc.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever had an allergic reaction to any medication? If yes please check below: _____	<input type="checkbox"/>	<input type="checkbox"/>
	Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Medicine: _____		
6.	Have you ever had an injury to your face or jaws?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever had surgery or X-Ray treatment for a tumor, growth or skin disease?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you have chest pain on exertion or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever had prolonged bleeding following a cut or extraction of a tooth?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever had blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family every had diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you have any disease, condition or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, please specify: _____			
13.	Would you like to have whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Do you want straighter teeth if invisible braces were possible?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever experienced an unusual reaction to a dental injection (novacaine)?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever had periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Women, are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
	Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATION CONSENT AND FINANCIAL POLICY

I hereby consent to and authorize my dentist of record to send records, contact my physician and to perform any tests or treatment that in his/her judgement are considered necessary or advisable for the detection, diagnosis and treatment of a disease state affecting me. I understand that there is a potential risk of permanent parathesia and/or anesthesia from dental injections. I understand that all fees are to be paid at the time services are rendered, unless otherwise arranged. I will be responsible for any reasonable attorney's fees to collect any unpaid balances.

SIGNATURE _____

Reviewed by _____