STEWART DENTAL

Medical History

1. Name of Medical Doctor:_____ Phone Number (Medical Dr.):_____
2. Are you taking any medications, or drugs? ☐ Yes ☐ No

   If yes, please list: _____
3. Do you have any drug allergies? ☐ Yes ☐ No

   If yes, please list: _____
4. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item:

Heart Failure	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Heart Disease or Attack	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Dialysis	☐ Yes	☐ No	A.I.D.S.	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Blood Transfusions	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Heart Surgery/Stents	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Cortisone Medication	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Sleep Apnea/Snoring	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No	Developmentally Disabled	☐ Yes	☐ No
Snoring	☐ Yes	☐ No						

5. Do you or have you ever had any type of cancer? ☐ Yes ☐ No

   If yes, please list: _____
6. Do you or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No

   If yes, please list: _____

FOR WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

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.

CONSENT:

1. The undersigned hereby authorize doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the 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 for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, 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. I hereby authorize my insurance benefits to be paid directly to Dr. Stewart. 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.

_____ _____

Signature of Responsible Party Date

_____ _____

Print Patients Name Dr. Signature