Medical History

Physician's name ____ Address ____

Phone__________________________ Physician's Email ____ Date of last visit ___________

Have you had any serious illnesses or operations? ☐ **Y** ☐ **N** If Yes, describe ____

Are you currently under physician care? ☐ **Y** ☐ **N** If Yes, describe ____

Have you ever had a blood transfusion? ☐ **Y** ☐ **N** If Yes, give approximate dates ____

Have you ever taken Fen-Phen/Redux? ☐ **Y** ☐ **N**

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ **Y** ☐ **N**

Women: Are you pregnant? ☐ **Y** ☐ **N** Nursing? ☐ **Y** ☐ **N** Taking birth control pills? ☐ **Y** ☐ **N**

Check Y for yes or N for no if you have or have not had any of the following:

☐ **Y** ☐ **N**	AIDS/HIV Positive	☐ **Y** ☐ **N**	Cough, persistent	☐ **Y** ☐ **N**	Jaw pain	☐ **Y** ☐ **N**	Shingles
☐ **Y** ☐ **N**	Anaphylaxis	☐ **Y** ☐ **N**	Cough up blood	☐ **Y** ☐ **N**	Kidney disease or malfunction	☐ **Y** ☐ **N**	Shortness of breath
☐ **Y** ☐ **N**	Anemia	☐ **Y** ☐ **N**	Diabetes	☐ **Y** ☐ **N**	Liver disease	☐ **Y** ☐ **N**	Skin rash
☐ **Y** ☐ **N**	Arthritis, Rheumatism	☐ **Y** ☐ **N**	Epilepsy	☐ **Y** ☐ **N**	Material allergies (latex, wool, metal chemicals)	☐ **Y** ☐ **N**	Spina Bifida
☐ **Y** ☐ **N**	Artificial heart valves	☐ **Y** ☐ **N**	Fainting	☐ **Y** ☐ **N**	Mitral valve prolapse	☐ **Y** ☐ **N**	Stroke
☐ **Y** ☐ **N**	Artificial joints	☐ **Y** ☐ **N**	Food allergies	☐ **Y** ☐ **N**	Nervous problems	☐ **Y** ☐ **N**	Surgical implant
☐ **Y** ☐ **N**	Asthma	☐ **Y** ☐ **N**	Glaucoma	☐ **Y** ☐ **N**	Pacemaker/Heart surgery	☐ **Y** ☐ **N**	Swelling of feet or ankles
☐ **Y** ☐ **N**	Atopic (allergy prone)	☐ **Y** ☐ **N**	Headaches	☐ **Y** ☐ **N**	Psychiatric care	☐ **Y** ☐ **N**	Thyroid disease or malfunction
☐ **Y** ☐ **N**	Back problems	☐ **Y** ☐ **N**	Heart murmur	☐ **Y** ☐ **N**	Rapid weight gain or loss	☐ **Y** ☐ **N**	Tobacco habit
☐ **Y** ☐ **N**	Blood disease	☐ **Y** ☐ **N**	Heart problems Describe___________	☐ **Y** ☐ **N**	Radiation treatment	☐ **Y** ☐ **N**	Tonsillitis
☐ **Y** ☐ **N**	Cancer	☐ **Y** ☐ **N**	Hemophilia/Abnormal bleeding	☐ **Y** ☐ **N**	Respiratory disease	☐ **Y** ☐ **N**	Tuberculosis
☐ **Y** ☐ **N**	Chemical dependency	☐ **Y** ☐ **N**	Herpes	☐ **Y** ☐ **N**	Rheumatic fever	☐ **Y** ☐ **N**	Ulcer/Colitis
☐ **Y** ☐ **N**	Chemotherapy	☐ **Y** ☐ **N**	Hepatitis	☐ **Y** ☐ **N**	Scarlet fever	☐ **Y** ☐ **N**	Venereal disease
☐ **Y** ☐ **N**	Circulatory problems	☐ **Y** ☐ **N**	Cortisone treatments	☐ **Y** ☐ **N**	High blood pressure		

List medications you are currently taking, if any:

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List drug allergies, if any:

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Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that the dentist to help determine appropriate and healthful dental treatment will use this information. If there is any change in my medical status, I will inform the dentist.

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

Payment is due in full at time of treatment unless prior arrangements have been approved.