

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Please check yes or no to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis,	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatism		Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
valves		Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
(with extractions or surgery)		Meds: _____		Swelling of Feet or	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on	
problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head or Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart		Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss,	
treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:		unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any hospital stays	<input type="checkbox"/> Yes <input type="checkbox"/> No
bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____		Explain _____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Do you wear		Are you taking birth		_____	
Contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

MEDICATIONS

Please list medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Patient's Signature

Date

Doctor's Signature
(I have read, agree to, and understand the statements listed above)

Date