

MEDICAL HISTORY

This medical history is important for your safety, and will assist us in caring for any special needs.

Family Physician _____ Phone # () _____

Address _____

Do you have a current medical problem? _____

If yes, please describe _____

Please list any medications you are currently taking _____

Women: Are you pregnant? _____ If yes, how many months? _____

Name of person to call in case of an emergency: _____

Relationship _____ Phone () _____

Have you ever had (please circle):

Heart Disease	yes	no	Artificial Heart Valve	yes	no
Heart Murmur	yes	no	Artificial Joints	yes	no
Rheumatic Fever	yes	no	Bleeding Problems	yes	no
Diabetes	yes	no	Venereal Disease	yes	no
Arthritis	yes	no	Cancer or Tumors	yes	no
Asthma	yes	no	AIDS/HIV	yes	no
Hepatitis	yes	no	Kidney/Liver Problems	yes	no
High Blood Pressure	yes	no	Allergies	yes	no
			Reactions to Medications	yes	no
			Which Ones? _____		

Have you ever been hospitalized or had a serious illness? _____

If yes, please explain _____

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that 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 financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (or legal guardian) _____ Date: _____

Date: _____ Dentist Signature _____