PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE ( ) _____ DATE OF LAST PHYSICAL _____

1. Are you under medical treatment now?.....YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness?.....YES NO
3. Are you taking any medications: (including non-prescription medicine)? .....YES NO
   If yes, what medication(s) are you taking: _____
   _____
   Are you taking any Osteoporosis Medication YES NO
   _____

4. **Women Only:**
   a) Are you pregnant or think you may be pregnant?..... YES NO
   b) Are you nursing ..... YES NO
   c) Are you taking birth control pills? ..... YES NO

5. Are you allergic to or have had any reactions to the following?
   Local anesthetics (novocaine)..... YES NO
   Penicillin or other antibiotics..... YES NO
   Sulfa Drugs..... YES NO
   Barbiturates ..... YES NO
   Sedatives..... YES NO

6. Do you have or have you had any of the following:

High Blood Pressure ..... YES NO	Heart disease ..... YES NO	Stroke..... YES NO
Heart Attack ..... YES NO	Cardiac Pacemaker.... YES NO	Tuberculosis..... YES NO
Rheumatic Fever ..... YES NO	Heart Murmur ..... YES NO	Radiation Therapy..... YES NO
Fainting/Seizures..... YES NO	Angina..... YES NO	Glaucoma..... YES NO
Asthma..... YES NO	Anemia..... YES NO	Liver Disease ..... YES NO
Low Blood Pressure..... YES NO	Emphysema..... YES NO	Heart Trouble..... YES NO
Epilepsy ..... YES NO	Cancer ..... YES NO	Respiratory Problems YES NO
Leukemia ..... YES NO	Arthritis..... YES NO	Diabetes ..... YES NO
Joint Replacements or Implants .... YES NO	Kidney Disease ..... YES NO	Thyroid Problem..... YES NO
AIDS or HIV infection..... YES NO	Sexually Transmitted Disease..... YES NO	Hepatitis/Jaundice..... YES NO
		Other _____

7. Date of last cleaning_____ 8. Date of Last Dental X-rays(Full Mouth Series)_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date:_____
Signature of patient (or parent if minor)