MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Bleeding tendency	❑	❑	Sexually transmitted diseases
❑	❑	High blood pressure	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	Low blood pressure				❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Mitral valve prolapse	❑	❑	Delay in healing	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Heart murmur	❑	❑	Hay fever / Sinus problems	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / Joint disease
❑	❑	Chest pain / Angina	❑	❑	Snoring	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Heart attack(s)	❑	❑	Sleep apnea / CPAP	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Irregular heart beat	❑	❑	Respiratory problems	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Cardiac pacemaker	❑	❑	Tuberculosis	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Heart surgery	❑	❑	Emphysema	❑	❑	Convulsions / Epilepsy	❑	❑	Stomach ulcers
❑	❑	Damaged heart valves	❑	❑	Do you smoke	❑	❑	Stroke	❑	❑	Tumor or growth
❑	❑	Pneumonia / Bronchitis / Chronic cough			*If so, # packs a day* _____	❑	❑	Thyroid trouble	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Diabetes	❑	❑	Are you on a diet
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Low blood sugar	❑	❑	Contact lenses
❑	❑	Anemia	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis			
❑	❑	Asthma	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble			

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin,Aspirin)
									❑	❑	Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 years.

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Do you have any known allergies

Please list any other medication or antibiotic you are allergic to: _____

Please list any allergies other than drug allergies: _____

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*

X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**