MEDICAL HISTORY

Physician's Name_____City_____Date of Last Physical_____

Are you sensitive or allergic to any of the following? (Please check if Yes)
Aspirin _____ Barbiturates_____Codeine _____ Latex _____ Sedatives _____
Dental Anesthetics _____ Jewelry/Metals _____

Any Antibiotics: E-Mycin____ Penicillin____ Sulfa____Tetracycline____Other____ Please List_____

Have you had any joint replacements? Y___N___
If Yes, please explain_____Approx. Date_____

Have you had a serious head or neck injury? Y___N___
If Yes, please explain_____Approx. Date_____

Are you currently taking any of the following blood thinners? Y___N___ If Yes, please circle the one you are taking.
Coumadin, Warfarin, Plavix, Heparin, Lovenox, Aggrenox, Aspirin

Have you ever had any of the following? (Please check if Yes)

___AFIB
___AIDS-HIV
___Anemia
___Angina
___Arthritis
___Artificial Heart Valves
___Artificial Joints
___Asthma
___Bleeding/clotting problems
___Breathing Problems
___Cancer
___Canker sores
___Chest pains
___Circulatory problems
___Diabetes
___Emphysema
___Epilepsy
___Fainting
___Hay fever/Allergies
___Headaches
___Hearing problems
___Heart Attack
___Heart Murmur
___Hepatitis
___High Blood Pressure
___Hypoglycemia
___Kidney Disease
___Leukemia
___Liver Disease
___Mitral Valve Prolapse
___Osteoperosis
___Pacemaker
___Psychiatric Care
___Radiation treatment
___Rheumatic Fever
___Shingles
___Sinus problems
___Stomach Problems
___Stroke
___Thyroid problem
___Tuberculosis
___Ulcer

Please list any medications you are taking or give us a list to copy:

_____
_____
_____
_____
_____

Do you suspect that you are pregnant? Y___N___ Pregnancy Due Date_____Are you taking birth control pills? Y___N___

Are you under the care of a physician? _____For what conditions?_____

Is there anything else we should know about your medical history?_____

Who should we call in case of an emergency?_____Phone #_____

Authorization and Financial Agreement

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize the dentist to release any information including diagnosis and the records of treatment to my insurance company and or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due on the date of service, including insurance deductibles and copays, unless other arrangements have been made.

SIGNATURE_____ DATE_____