

MEDICAL HISTORY

Patient's Name: _____ Date of Last Visit: _____

Have you had any serious illness or operations? Yes No If yes, please describe: _____

(Women Only)

Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

CIRCLE THE APPROPRIATE ANSWER FOR THE CONDITIONS WHICH YOU HAVE OR HAVE HAD

AIDS	YES NO	Emphysema	YES NO	Psychiatric Care	YES NO
Anemia	YES NO	Epilepsy/Seizures	YES NO	Radiation Treatment	YES NO
Arthritis, Rheumatism	YES NO	Fainting	YES NO	Respiratory Disease	YES NO
Artificial Heart Valves	YES NO	Glaucoma	YES NO	Rheumatic Fever	YES NO
Artificial Joints	YES NO	Heart Murmur	YES NO	Scarlet Fever	YES NO
Asthma	YES NO	Heart Problems	YES NO	Shortness of Breath	YES NO
Back Problems	YES NO	Describe: _____		Skin Rash	YES NO
Blood Disease	YES NO	Hemophilia	YES NO	Stroke	YES NO
Blood Transfusion	YES NO	Hepatitis/Jaundice	YES NO	Thyroid Problems	YES NO
Cancer	YES NO	H Blood Pressure	YES NO	Describe: _____	
Chemical Dependency	YES NO	HIV Positive	YES NO	Tobacco Habit	YES NO
Chemotherapy	YES NO	Jaw Pain	YES NO	Tonsillitis	YES NO
Circulatory Problems	YES NO	Kidney Disease	YES NO	Tuberculosis	YES NO
Cortisone Treatments	YES NO	Liver Disease	YES NO	Ulcer	YES NO
Cough, Persistent	YES NO	Mitral Valve Pro.	YES NO	Venereal Disease	YES NO
Cough Up Blood	YES NO	Nervous Problems	YES NO	Require Medication	YES NO
Diabetes	YES NO	Pacemaker	YES NO	Type: _____	

Do you have any disease, condition, or problem not listed? _____

MEDICATIONS

Have you taken any prescription diet pills? Yes No

List all medications currently taken including
Over the counter medication:

ALLERGIES

Aspirin Latex
 Codeine Local Anesthetic
 Erythromycin Penicillin
 Iodine Sulfa
 Other: _____

Medical History Update

<input type="checkbox"/> No Changes	<input type="checkbox"/> Changes Made	Signature _____	Date _____
<input type="checkbox"/> No Changes	<input type="checkbox"/> Changes Made	Signature _____	Date _____
<input type="checkbox"/> No Changes	<input type="checkbox"/> Changes Made	Signature _____	Date _____
<input type="checkbox"/> No Changes	<input type="checkbox"/> Changes Made	Signature _____	Date _____

Please initial on the appropriate line

I have read and answered the above questions to the best of my knowledge.
 I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me for services rendered.
 I authorize the use of this signature on all insurance submissions.
 I authorize the dentist to release all information necessary to secure the payment of benefits.

Our office will file your insurance at no extra charge. Please understand your insurance is a contract between you and your insurance company. Any balance not paid by your insurance company in 90 days is your responsibility.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

SIGNATURE: _____ DATE: _____