

MEDICAL INFORMATION

- 1. Are you having pain or discomfort at this time? Yes No
2. Have you been a patient in the hospital during the past two years? Yes No
3. Have you been under the care of a medical doctor during the past two years? Yes No
Physician Name Phone
4. Have you taken any medication or drugs during the past two years? Yes No
5. Are you taking any medication or drugs now? Yes No
If yes, please list
6. Are you sensitive or allergic to any medication or anesthetic? Yes No
If yes, please list
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.
Heart Failure Yes No Artificial Joints Yes No Hepatitis B (serum) Yes No
Heart Disease or Attack Yes No Kidney Trouble Yes No Venereal Disease Yes No
Angina Pectoris Yes No Ulcers Yes No A.I.D.S. Yes No
Congenital Heart Disease Yes No Diabetes Yes No H.I.V. Positive Yes No
Heart Murmur Yes No Thyroid Problems Yes No Cold Sores/Blisters Yes No
High Blood Pressure Yes No Glaucoma Yes No Blood Transfusion Yes No
Arteriosclerosis Yes No Cancer Yes No Hemophia Yes No
Mitral Valve Prolapse Yes No Emphysema Yes No Anemia Yes No
Artificial Heart Valve Yes No Chronic Cough Yes No Sickle Cell Disease Yes No
Heart Pacemaker Yes No Tuberculosis Yes No Bruise Easily Yes No
Heart Surgery Yes No Asthma Yes No Liver Disease Yes No
Rheumatic Fever Yes No Hay Fever Yes No Yellow Jaundice Yes No
Arthritis Yes No Allergies or Hives Yes No Epilepsy or Seizures Yes No
Rheumatism Yes No Sinus Trouble Yes No Fainting or Dizzy Yes No
Cortisone Medicine Yes No Radiation Therapy Yes No Nervousness Yes No
Drug Addiction Yes No Chemotherapy Yes No Tumors Yes No
Stroke Yes No Hepatitis A Yes No Developmentally Disabled Yes No
8. When you walk up stairs or take a walk, do you ever have to stop because of chest pain, shortness of breath, or because you are very tired? Yes No
9. Do your ankles swell during the day? Yes No
10. Do you use more than two pillows to sleep? Yes No
11. Have you lost or gained more than 10 pounds in the past year? Yes No
12. Do you ever wake up from sleep and feel short of breath? Yes No
13. Are you on a special diet? Yes No
14. Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list

FOR WOMEN ONLY:

Are you pregnant? Yes No If yes, what month? Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature Date

CONSENT

- 1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient). I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Parent/Responsible Party Signature Date Witness

FOR OFFICE USE: Reviewed by Dr. Date