NAME: DATE OF BIRTH:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CHECK YES OR NO)

	YES	NO
Hiatal Hernia or stomach trouble	——	——
Rheumatic Fever	——	——
Heart Disease	——	——
Angina (chest pain)	——	——
High or Low Blood Pressure	——	——
Stroke	——	——
Kidney trouble	——	——
Arthritis	——	——
Tuberculosis	——	——
Malignancies (cancer)	——	——
Asthma or emphysema	——	——
Productive cough or recent cold	——	——
Hay fever, allergies, hives	——	——
Liver disease, jaundice, hepatitis	——	——
Thyroid disorder	——	——
Epilepsy seizures, convulsions	——	——
Difficulties hearing	——	——
Eye Disease	——	——
Psychiatric or nervous disorder	——	——
Severe headaches	——	——
Herbal supplements	——	——
Sleep Apnea	——	——
Diabetes	——	——

	YES	NO
HIV positive	——	——
AIDS	——	——
Alcohol	——	——
Do you smoke? ____ Packs per day?_____	——	——
Complications following childhood disease	——	——
Frequent fainting	——	——
Sinus trouble	——	——
Trouble with extractions	——	——
Poor experiences with dentistry	——	——
Excessive or prolonged bleeding	——	——
Anemia or blood disorder	——	——
Sickle Cell disease or Trait	——	——
Pregnant? If so, what month _____		
History of anesthesia problems	——	——

Adverse effects or reaction to local anesthetic

(Novocain) or any other drug reactions?

_____

_____

Joint replacement: hip knee elbow shoulder

Pre-Medication before dental treatment ? ..... ____ ____

Past surgeries: _____

_____

_____

THE ABOVE MEDICAL HISTORY IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO ROUTINE PROCEDURES DEEMED TO BE NECESSARY FOR DIAGNOSIS AND TREATMENT.

_____ _____

PATIENT OR GUARDIAN DATE

I UNDERSTAND THAT ONCE I ACCEPT TREATMENT, I WILL BE BOUND BY THE FINANCIAL POLICY OF THE OFFICE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COSTS INCURRED IN THEIR CARE, AND FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT.

_____ _____

PATIENT OR GUARDIAN DATE