MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: ______________________________

____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) If, so when? ______________________________

Have you ever had any of the following problems diseases or medical

Y N	Abnormal Bleeding	Y N	Hepatitis 'B' or 'C
Y N	Alcohol/Drug Abuse	Y N	Herpes/Fever Blisters
Y N	Anemia	Y N	High Blood Pressure
Y N	Arthritis	Y N	HIV+/AIDS
Y N	Artificial Bones/Joints	Y N	Hospitalized for any reason
Y N	Asthma	Y N	Kidney Problems
Y N	Back Problems	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Low Blood Pressure
Y N	Cancer/Chemotherapy	Y N	Lupus
Y N	Chest Pains / Angina	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Pacemaker
Y N	Diabetes	Y N	Psychiatric Problem
Y N	Difficilty Breathing	Y N	Radiation Treatment
Y N	Emphysema	Y N	Rheumatic/Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sickle Cell Disease/ Traits
Y N	Glaucoma	Y N	Sinus Problems
Y N	Hay Fever	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Stent	Y N	Ulcers
Y N	Heart Surgery	Y N	Venereal Disease
Y N	Hemophilia		

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of following?

Y N	Aspirin	Y N	Erythromycin	Y N	Sulfa Drug
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list any other drugs/materials that you are allergic to: _______

____

For Women: Are you taking birth control pill? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due date: ____________

Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Why have you come to the dentist today? ______________________________

____

Do you require antibiotics before dental treatment? ☐Yes ☐No

Are you currently in pain? ☐Yes ☐No

Have you ever had a serious/difficult problem associated with any previous dental treatment? ☐Yes ☐No

Have you ever had gum treatment? ☐Yes ☐No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD) ? ☐Yes ☐No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? __________

How many times a day do you brush?__________

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Are your teeth sensitive to heat, cold, or anything else? _________

CONSENT FOR TREATMENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsility to inform this office of any changes in my medical status. I authorize and give consent to the doctor and his staff to administer treatment, including but not limited to, local anesthesia, analgesia, I also understand that the use of these agents and some procedures embodies a certain risk. A service charge of 1.5% per month (18% per year) but no more than maximum rate permissible under state law will be charged on the unpaid principal balance on all accounts not paid within 90 days of treatment date.
I understand that responsibility of payment for Dental Service provided in this office for myself or my dependent is mine. Unless prior arrangements are made, accounts are to be paid on the date which services are provided. I hereby authorize that the payment from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees, agree to pay any and all cost of suit, collection, and attorney fees. I grant permission to you or your assigns, to telephone me at home or work to discuss matters related to this form.

______________________________ ____/____/______

Signature **Date**

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein. Initial: _________ Date: ____/____/______

Doctor's Comments: ______________________________

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