

Your Medical History

- Are you under a physician's care at this time? YES NO
- Have you ever been hospitalized or had a major operation? YES NO
- Have you ever had an injury to your head or neck? YES NO
- Are you on a special diet? YES NO
- Do you smoke? YES NO
- Would you like to quit smoking? YES NO

Are you currently taking any medications, drugs or pills? Please list below

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO:

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Local Anesthetics? | <input type="checkbox"/> YES <input type="checkbox"/> NO Aspirin? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Penicillin? | <input type="checkbox"/> YES <input type="checkbox"/> NO Other? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Codeine/ other narcotics? | |
-

Have you ever been informed that you need to be pre-medicated before dental procedures?

- | | | |
|--|--|---|
| Heart trouble/disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Hay Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney Carrier <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mitral Valve Prolapse <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO | Renal Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Heart Valve <input type="checkbox"/> YES <input type="checkbox"/> NO | Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO | TB <input type="checkbox"/> YES <input type="checkbox"/> NO | Parathyroid Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO | Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO | Arthritis (Gout) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Attack (Date) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO | X-Ray Treatment <input type="checkbox"/> YES <input type="checkbox"/> NO | Artificial Joint/s <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congestive Heart Disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Chemotherapy <input type="checkbox"/> YES <input type="checkbox"/> NO | AIDS or HIV Positive <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO | Digestive Tract Disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Herpes <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Low Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO | Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Recent Weight Loss <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Scarlet Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO | Are you Scared? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Excessive Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO | Hypoglycemia <input type="checkbox"/> YES <input type="checkbox"/> NO | Fainting or Dizzy <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Shortness of Breath <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Alzheimer's Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Lung Disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis A (infectious) <input type="checkbox"/> YES <input type="checkbox"/> NO | Pregnant (trimester) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Frequent Cough <input type="checkbox"/> YES <input type="checkbox"/> NO | Hep. B (serum) / Carrier? <input type="checkbox"/> YES <input type="checkbox"/> NO | Other <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Latex Allergy <input type="checkbox"/> YES <input type="checkbox"/> NO | Hep C <input type="checkbox"/> YES <input type="checkbox"/> NO | |

Medical Updates

Authorization

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF
THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.
In the case of default I promise to pay the balance, any legal interest, and the cost of collection
which include a reasonable attorney's fee on my account. A \$25.00 late cancellation / no show fee
can be added to my account if frequent broken appointments make it necessary.

**To the best of my knowledge, all the above answers are correct. If there are
any changes in my medical health I will inform the dentist before my next
appointment or before any treatment is started. I have read and agree to all
the terms outlined on this form.**

PERSON SIGNING MUST BE 18 YEARS OR OLDER

X _____ **Date:** _____