

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Medical Physician: _____ Address: _____ Phone: _____

1. Are you allergic to or have any reactions to the following:

- ☐ Local Anesthetics (e.g. Novocaine)
- ☐ Penicillin (Amoxicillin)
- ☐ Other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Codeine
- ☐ Ultram (Tramadol)
- ☐ Any Metal (e.g. Nickel, Mercury, etc.)
- ☐ Latex/Rubber
- Other (please list) _____

2. Women Only:

- Are you pregnant, or think you may be? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

3. Are you under medical treatment now? Yes No

4. Have you been hospitalized for any surgical operations or serious illness within the last 5 years? Yes No
if yes, explain: _____

5. Are you taking any medication(s) including non-prescription medicine?
Yes / No If yes, what medication(s) are you taking? _____

6. Do you use tobacco? Yes No

7. Do you use any illegal drugs? Yes No

8. Are you wearing contact lenses? Yes No

9. Are you taking blood thinners? Yes No

10. Do you take aspirin daily? Yes No

11. Pharmacy: _____

12. Do you have, or have you ever had, any of the following? (Check the box if it applies to you)

- | | | | |
|--|--|--|---|
| ☐ Alcohol Abuse | ☐ Drug Abuse | ☐ High Blood Pressure | ☐ PTSD |
| ☐ Anemia | ☐ Emphysema | ☐ HIV Infection/ AIDS | ☐ Radiation Therapy |
| ☐ Angina Pectoris | ☐ Epilepsy | ☐ Joint Replacement | ☐ Respiratory Issues |
| ☐ Arthritis | ☐ Fainting Spells | ☐ Kidney Problems/Disease | ☐ Rheumatic Fever |
| ☐ Artificial Heart Valves | ☐ Fever Blisters | ☐ Leukemia | ☐ Shingles |
| ☐ Asthma | ☐ Frequent Headaches | ☐ Lichen Planus | ☐ Sickle Cell Anemia |
| ☐ Bleeding/Clotting Disorder | ☐ Glaucoma (Wide or Narrow) | ☐ Liver Disease | ☐ Sinus Problems |
| ☐ Blood Transfusion: Year _____ | ☐ Hay Fever | ☐ Low Blood Pressure | ☐ Smoker |
| ☐ Cancer, Type: _____ | ☐ Heart Attack | ☐ Migraines | ☐ Stroke: Year _____ |
| ☐ Chest Pains | ☐ Heart Disease | ☐ Mitral Valve Prolapse | ☐ Thyroid Problems |
| ☐ Colitis/Stomach Troubles | ☐ Heart Murmur | ☐ Organ Transplant | ☐ Tuberculosis |
| ☐ Congenital Heart Defect | ☐ Heart Trouble | ☐ Pace Maker | ☐ Ulcers |
| ☐ Cosmetic Surgery | ☐ Hemophilia | ☐ Pneumocystis | ☐ STD: _____ |
| ☐ Diabetes Type: _____ | ☐ Hepatitis Type: _____ | ☐ Psychiatric Problems | Other: _____ |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be financially responsible for payments for all services rendered at each appointment on behalf of myself or my dependents. In the event that no payments are made within 90 days of the due date, I agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

Sign: _____

Date: _____