1. Physician's Name: _____ Phone Number: _____

2. Have you taken any medications or drugs during the past 2 years? ☐ Yes ☐ No
If so, please list below:

3. Are you taking any medications, drugs or pills at the present? ☐ Yes ☐ No
If so, please list below:

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? If so, please list: ☐ Yes ☐ No

5. Please check any of the following that you have had, or have at the present:

☐ Heart (Surgery, Disease, Attack)	☐ Ulcers	☐ Hepatitis A (infections) B (Serum)
☐ Chest Pain	☐ Diabetes	☐ Venereal Disease
☐ Congenital Heart Disease	☐ Thyroid Problems	☐ A.I.D.S
☐ Heart Murmur	☐ Glaucoma	☐ H.I.V. Positive
☐ High Blood Pressure	☐ Contact Lenses	☐ Cold Sores/Fever Blisters
☐ Mitral Valve Prolapse	☐ Emphysema	☐ Blood Transfusion
☐ Artificial Heart Valve	☐ Chronic Cough	☐ Hemophilia
☐ Heart Pacemaker	☐ Tuberculosis	☐ Sickle Cell Disease
☐ Rheumatic Fever	☐ Asthma	☐ Bruise Easily
☐ Arthritis/Rheumatism	☐ Hay Fever	☐ Liver Disease
☐ Cortisone Medicine	☐ Latex Sensitivity	☐ Yellow Jaundice
☐ Swollen Ankles	☐ Allergies or Hives	☐ Neurological Disorders
☐ Stroke	☐ Sinus Trouble	☐ Epilepsy or Seizures
☐ Diet (Special/Restricted)	☐ Radiation Therapy	☐ Fainting or Dizzy Spells
☐ Artificial Joints (hip, knee, etc)	☐ Chemotherapy	☐ Nervous/ Anxious
☐ Kidney Trouble	☐ Tumors	☐ Psychiatric/Psychological Care

6. Do you use more than two pillows to sleep? ☐ Yes ☐ No

7. Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

8. Do you have or have you had any disease, condition, or problem not listed? If yes please list: ☐ Yes ☐ No

9. **Women**: Are you pregnant? ☐ Yes, ____ Months ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking Birth Control? ☐ 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 to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ **Date** _____

PAYMENT TERMS

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payment in full is not made at the time of service, I understand that payment shall be due within 30 days from the date of invoice. Should I fail to pay the full amount of the invoice within said time period, I agree to pay interest at the rate of 1% per month on the balance until paid in full.

I further understand that failure to pay the indebtedness in full within 30 days of the date of the invoice will render me in default. In the event that it becomes necessary to employ an attorney for collection, I agree to pay reasonable attorney fees of 33% of the indebtedness owed, and all collection and court costs incurred.
I have read and understand the payment terms stated above.

Patient: _____ **Date** _____