Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician_____Location_____Ph#_____

Are you under a physician's care now? ○Yes ○No If yes, please explain_____

Have you ever been hospitalized or had major operation? ○Yes ○No If yes, please explain_____

Have you ever had a serious head or neck injury? ○Yes ○No If yes, please explain_____

Are you taking any medications, pills, or drugs? ○Yes ○No If yes, please list _____

Do you take, or have you taken Phen-Fen or Redux? ○Yes ○No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No _____

_____

Are you on a special diet? ○Yes ○No _____

Do you use tobacco? ○Yes ○No _____

Do you use controlled substances? ○Yes ○No _____

- Women Only: Are you pregnant/trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following? □Aspirin □Penicillin □Codeine □Local Anesthetic □Acrylic □Metal □Latex □Sulfa

□Other: If yes please explain_____

Do you have, or have you had any of the following?

AIDS/HIV positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions	○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy/Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizzy Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/ Disease	○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No	Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care	○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No	Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Sexually Transmitted Infection Yellow Jaundice	○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No

Have you ever had any serious illness not listed above? ○Yes ○No____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_________________________________DATE_____________________