If yes, for what? Physician's Name: Address: City: State: Have you taken any prescription, herbal, or over the counter medications in the past two years? If yes, please list name and dosage: Are you aware of having an allergic (or adverse) reaction to any medication or substance? Are you aware of having an allergic (or adverse) reaction to any medication or substance? Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES If yes, please list: Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Iceart Ulcers YES NO Diabetes YES NO Diabetes YES NO Venereal Disease YES NO AIDS YES NO AIDS YES NO AIDS YES NO Formic Problems YES NO Collaccoma YES NO Holy Positive YES NO Glaucoma YES NO Holy Positive YES NO Formic Cough YES NO Blisters YES NO Blisters YES NO Hompic Cough YES NO Hompic Easily YES NO Hom	PATIENT NAME:						MEDICAL HISTORY		
Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES If yes, please list: Have you been a patient in the hospital during the past five years? VES Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Iteant Ulcers YES NO Hepatitis A or B YES NO Contact Lenses YES NO Hepatitis A or B YES NO Hepatitis Hemotitis Hem	1. Have you been under	r the car	e of a 1	nedical doctor during th	ne past two	years'	?	YES	N
Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES If yes, please list: Have you been a patient in the hospital during the past five years? VES Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Iteant Ulcers YES NO Hepatitis A or B YES NO Contact Lenses YES NO Hepatitis A or B YES NO Hepatitis Hemotitis Hem	It yes, for what?				DI	ono:			
Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES If yes, please list: Have you been a patient in the hospital during the past five years? VES Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Iteant Ulcers YES NO Hepatitis A or B YES NO Contact Lenses YES NO Hepatitis A or B YES NO Hepatitis Hemotitis Hem	Address:				11	ione	State:		
Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES If yes, please list: Have you been a patient in the hospital during the past five years? VES Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Iteant Ulcers YES NO Hepatitis A or B YES NO Contact Lenses YES NO Hepatitis A or B YES NO Hepatitis Hemotitis Hem	Have you taken any	nrescrin	tion he	erhal or over the counter	er medicat	ions in	the past two years?	VES	NO
If yes, please list: Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have an at present. Circle "YES" NO AIDS" YES NO HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO Heart Pacenaker YES NO Contact Lenses YES NO Hemophilia YES NO Latex Sensitivity YES NO Liver Disease YES NO Wolfen Ankles YES NO Latex Sensitivity YES NO Liver Disease YES NO Wolfen Ankles YES NO Allergies or Hives YES NO Neurological Disorders YES NO Hellow Jaundice YES NO Neurological Disorders YES NO Neurological Disorders YES NO Hellow Jaundice YES NO	If yes, please	list nan	ne and	dosage:		10115 111	the past two years:	TE5	111
If yes, please list: Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Indicate which of the following you have an at present. Circle "YES" NO AIDS" YES NO HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO Heart Pacenaker YES NO Contact Lenses YES NO Hemophilia YES NO Latex Sensitivity YES NO Liver Disease YES NO Wolfen Ankles YES NO Latex Sensitivity YES NO Liver Disease YES NO Wolfen Ankles YES NO Allergies or Hives YES NO Neurological Disorders YES NO Hellow Jaundice YES NO Neurological Disorders YES NO Neurological Disorders YES NO Hellow Jaundice YES NO									
Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item. Iteart Ulcers YES NO Hepatitis A or B YES Now Weneral Disease YES NO Diabetes YES NO Hepatitis A or B YES Now Weneral Disease YES NO Diabetes YES NO AIDS YES NO Organial Heart Disease YES NO Glaucoma YES NO HIV Positive YES NO Glaucoma YES NO HIV Positive YES NO Glaucoma YES NO HIV Positive YES NO HIV Positive YES NO Eart Murmur YES NO Contact Lenses YES NO HIV Positive YES NO HIV Positive YES NO Eart Murmur YES NO Contact Lenses YES NO HIV Positive YES NO HEAD HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO HEAD HIV POSITIVE YES NO HIV	3. Are you aware of having an allergic (or adverse) reaction to any medication or substance?								N
leart Burgery, Disease, Attack) YES NO Diabetes YES NO Hepatitis A or B YES Normal Surgery, Disease, Attack) YES NO Diabetes YES NO Venereal Disease YES NO Ongenital Heart Disease YES NO Thyroid Problems YES NO AIDS YES NO Ongenital Heart Disease YES NO Glaucoma YES NO HIV Positive YES NO Ongenital Heart Disease YES NO Glaucoma YES NO HIV Positive YES NO Ongenital Heart Disease YES NO Contact Lenses YES NO Cold Sores/Fever YES NO Eart Murmur YES NO Contact Lenses YES NO Cold Sores/Fever YES NO Emphysema YES NO Blisters YES NO Hitral Valve Prolapsed YES NO Chronic Cough YES NO Blood Transfusion YES NO Hemophilia YES NO Hemophilia YES NO Sick Cell Disease YES NO Asthma YES NO Sick Cell Disease YES NO Asthma YES NO Sick Cell Disease YES NO Hemophilia YES NO Hay Fever YES NO Bruise Easily YES NO Intertritis/Rhematism YES NO Hay Fever YES NO Bruise Easily YES NO Online On Allergies of Hives YES NO Hemophilia YES NO Herois Sorting YES NO Herois January YES NO Fainting or Tumors YES NO Fainting or Tu	4. Have you been a patient in the hospital during the past five years?								N
Surgery, Disease, Attack) VES NO Diabetes YES NO Hest Pain YES NO Thyroid Problems YES NO AIDS YES NO Onogenital Heart Disease YES NO Glaucoma YES NO Glaucoma YES NO HIV Positive YES NO Glob Sores/Fever YES NO Glob Sores/Fever YES NO Contact Lenses YES NO Cold Sores/Fever YES NO Itinity Version Thyroid Problems YES NO Cold Sores/Fever YES NO Itinity Version Thyroid Problems YES NO HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO HIV Positive YES NO Hittinity Version YES NO Cold Sores/Fever YES NO Hittinity Version Hittinity Version Hemophilia YES NO Hemophilia YES NO Hemophilia YES NO Hemophilia YES NO Hay Fever YES NO Hay Fever YES NO Hemophilia YES NO Hay Fever YES NO Hay Fever YES NO Hemophilia YES NO Hay Fever YES NO Hemophilia YES NO Hay Fever YES NO Hemophilia YES NO Holiary Disease YES NO Hay Fever YES NO Hemophilia YES NO Hay Fever YES NO Hemophilia YES NO Hay Fever YES NO Hemophilia YES NO Holiary Disease YES NO Hay Fever YES NO Hemophilia YES NO Hay Fever YES NO Hay Fever YES NO Hemophilia YES NO Holiary Disease YES NO Hemophilia YES NO Hay Fever YES NO Hemophilia YES NO Holiary Disease YES NO Hay Fever YES NO Holiary Disease YES NO Hittinity Disease YES NO Holiary Disease YES NO Holiar	Indicate which of	of the fo	ollowing	g you have had, or have	at present	. Circle	e "YES" or "NO" to each	ı item.	
thest Pain YES NO Thyroid Problems YES NO AIDS YES NO generalial Heart Disease YES NO Glaucoma YES NO HIV Positive YES NO teart Murmur YES NO Contact Lenses YES NO HIV Positive YES NO tigh Blood Pressure YES NO Emphysema YES NO Blisters YES NO trifficial Heart Valve YES NO Emphysema YES NO Blood Transfusion YES NO Tuberculosis YES NO Homophilia YES NO thempophilia YES NO Homophilia YES NO Repideal Disorders YES NO Homophilia YES NO Repideal Disorders YES NO Homophilia YES NO	Heart			Ulcers	YES	NO	Hepatitis A or B	YES	N(
leart Murmur YES NO Glaucoma YES NO HIV Positive YES NO leart Murmur YES NO Contact Lenses YES NO Cold Stores/Fever YES NO Contact Lenses YES NO Cold Stores/Fever YES NO Emphysema YES NO Blood Transfusion YES NO Interval Valve Prolapsed YES NO Emphysema YES NO Blood Transfusion YES NO Interval Valve YES NO Tuberculosis YES NO Hemophilian YES NO Eart Pacemaker YES NO Asthma YES NO Hemophilian YES NO HEMOPHILIA	(Surgery, Disease, Attack)	YES	NO	Diabetes	YES	NO	Venereal Disease	YES	N(
ongenital Heart Disease YES NO Glaucoma YES NO HIV Positive YES NO leart Murmur YES NO Contact Lenses YES NO Cold Sores/Fever YES NO ligh Blood Pressure YES NO Emphysema YES NO Blisters YES NO Chronic Cough YES NO Blood Transfusion YES NO Intridicial Heart Valve Prolapsed YES NO Chronic Cough YES NO Blood Transfusion YES NO Interculosis YES NO Hemophilia YES NO Sickle Cell Disease YES NO Heave YES NO Hemophilia YES NO Sickle Cell Disease YES NO Hemophilia YES NO Sickle Cell Disease YES NO Hemophilia YES NO Hemo	Chest Pain	YES	NO	Thyroid Problems	YES	NO	AIDS	YES	N(
ligh Blood Pressure YES NO Emphysema YES NO Blisters YES NO Hitral Valve Prolapsed YES NO Chronic Cough YES NO Blood Transfusion YES No Intridicial Heart Valve YES NO Tuberculosis YES NO Hemophilia YES NO Hemophilia YES NO Hemophilia YES NO Asthma YES NO Sickle Cell Disease YES No Hemophilia YES NO Asthma YES NO Sickle Cell Disease YES No Hemophilia YE		YES	NO		YES	NO	HIV Positive	YES	NO
fligh Blood Pressure YES NO Emphysema YES NO Blisters YES NO Itital Valve Prolapsed YES NO Chronic Cough YES NO Blood Transfusion YES Notificial Heart Valve YES NO Tuberculosis YES NO Hemophilia YES Not Hemophilia YES NO Hater Pacemaker YES NO Asthma YES NO Sickle Cell Disease YES Note Have Pacemaker YES NO Asthma YES NO Bruise Easily YES NO Hater Sensitivity YES NO Bruise Easily YES NO Latex Sensitivity YES NO Liver Disease YES Note International Provided P		YES	NO		YES	NO	Cold Sores/Fever	YES	N(
Afteral Valve Prolapsed YES NO Chromic Cough YES NO Blood Transfusion YES No Instrtificial Heart Valve YES NO Tuberculosis YES NO Hemophilia YES No Ident Pacemaker YES NO Asthma YES NO Sickle Cell Disease YES No Hemophilia YES NO Sickle Cell Disease YES No Hemophilia YES NO Sickle Cell Disease YES No Hay Fever YES NO Bruise Easily YES No Intrintits/Rheumatism YES NO Latex Sensitivity YES NO Evilosease YES No Intrintits/Rheumatism YES NO Hay Fever YES NO Bruise Easily YES No Intrintits/Rheumatism YES NO Hay Fever YES NO Bruise Easily YES No Intrintits/Rheumatism YES NO Allergies or Hives YES NO Liver Disease YES No Wollen Ankles YES NO Allergies or Hives YES NO Vellow Jaundice YES No Wollen Ankles YES NO Sinus Trouble YES NO Rediation Therapy YES NO Epilepsy or Seizures YES No Intrintificial Joints YES NO Radiation Therapy YES NO Epilepsy or Seizures YES No Intrintificial Joints YES NO Chemotherapy YES NO Fainting or Tumors YES NO Fainting or Nervous/Anxious YES No Introke YES NO Paychiatric/ Psychological Care YES NO Psychiatric/ Psychological Care YES NO Nervous/Anxious YES NO Psychiatric/ Psychological Care YES NO Nervous/Anxious YES NO Psychiatric/ Psychological Care YES NO Nervous/Anxious YES NO Psychiatric/ Psychological Care YES NO Nervous/Anxious YES NO Nerv		YES	NO		YES	NO	Blisters	YES	N(
cutificial Heart Valve YES NO Tuberculosis YES NO Hemophilia YES NO Heart Pacemaker YES NO Asthma YES NO Sickle Cell Disease YES No Heurmatic Fever YES NO Hay Fever YES NO Bruise Easily YES Nothermatism YES NO Latex Sensitivity YES NO Liver Disease YES Notrisone Medicine YES NO Latex Sensitivity YES NO Liver Disease YES Notrisone Medicine YES NO Allergies or Hives YES NO Vellow Jaundice YES Nowledge Note of Note of Neurological Disorders YES Note of Neurological Disorders YES Note (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Note (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Note of Neurological Disorders YES Note of Neurological Property of Neurol		YES	NO		YES	NO	Blood Transfusion	YES	N(
leart Pacemaker YES NO Asthma YES NO Sickle Cell Disease YES Nothumatic Fever YES NO Hay Fever YES NO Bruise Easily YES Noth Thirthitis/Rheumatism YES NO Latex Sensitivity YES NO Liver Disease YES Noth Thirthitis/Rheumatism YES NO Latex Sensitivity YES NO Liver Disease YES Noth Thirthitis/Rheumatism YES NO Latex Sensitivity YES NO Liver Disease YES Noth Thirthitis/Rheumatism YES NO Allergies or Hives YES NO Yellow Jaundice YES Nowled (Special/Restricted) YES NO Sinus Trouble YES NO Neurological Disorders YES Noth (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Noth (Special/Restricted) YES NO Chemotherapy YES NO Fainting or Tumors YES NO Dizzy Spells YES Noth (Special/Restricted) YES NO Neurological Disorders YES Noth (Special/Restricted) YES NO Neurological Care YES Noth (Special/Restricted) YES Not		YES	NO		YES	NO	Hemophilia	YES	No
theumatic Fever YES NO Hay Fever YES NO Bruise Easily YES NO criticitis/Rheumatism YES NO Latex Sensitivity YES NO Liver Disease YES NO Intrinsion Medicine YES NO Allergies or Hives YES NO Liver Disease YES NO Wollen Ankles YES NO Allergies or Hives YES NO Neurological Disorders YES NO Wollen Ankles YES NO Sinus Trouble YES NO Neurological Disorders YES NO Wollen Ankles YES NO Radiation Therapy YES NO Epilepsy or Seizures YES NO Unit filter and the Seizure YES NO Epilepsy or Seizures YES NO Epilepsy o	Heart Pacemaker	YES	NO		YES	NO			No
contisting Meumatism YES NO Latex Sensitivity YES NO Liver Disease YES Notrition Medicine YES NO Allergies or Hives YES NO Yellow Jaundice YES NO Wollen Ankles YES NO Sinus Trouble YES NO Neurological Disorders YES Note (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Note (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Note (Special/Restricted) YES NO Chemotherapy YES NO Fainting or Tumors YES NO Dizzy Spells YES NO Towns YES NO Psychiatric/Psychological Care YES NO Psychiatric/Psychological Care YES NO Psychiatric/Psychological Care YES NO Psychological	Rheumatic Fever				YES	NO	Bruise Easily		NO
Cortisone Medicine YES NO Allergies or Hives YES NO Yellow Jaundice YES No wollen Ankles YES NO Sinus Trouble YES NO Neurological Disorders YES NO Epilepsy or Seizures YE	Arthritis/Rheumatism			2					NO
wollen Ankles YES NO Sinus Trouble YES NO Neurological Disorders YES Note (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Note (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Note (Spilepsy or Seizures) YES NO Chemotherapy YES NO Fainting or supplied to the seizure of the sei	Cortisone Medicine								N(
Diet (Special/Restricted) YES NO Radiation Therapy YES NO Epilepsy or Seizures YES Notificial Joints YES NO Chemotherapy YES NO Fainting or Injuny Nervous/Anxious YES NO Dizzy Spells YES Notiques YES NO Dizzy Spells YES Notificial Joints YES NO Chemotherapy YES NO Dizzy Spells YES Notificial Joints YES NO Dizzy Spells YES Notificiant Trouble YES NO Nervous/Anxious YES Notificianty Trouble YES NO Nervous/Anxious YES Notificianty Trouble YES NO Psychiatric/ Psychological Care YES NO Psychological Care YES Notificianty Psychological Care Notificianty Psychological Care YES Notificianty Psychological Care Notificianty Psyc	Swollen Ankles								N(
Artificial Joints yes NO Chemotherapy YES NO Fainting or pip, knees) Tumors YES NO Dizzy Spells YES NO troke YES NO Dizzy Spells YES NO Dizzy Spells YES NO Dizzy Spells YES NO Dizzy Spells YES NO Nervous/Anxious YES NO Nervous/Anxious YES NO Psychiatric/ Psychiatric/ Psychological Care YES NO Psychological Care YES NO Nervous/Anxious YES NO Nervous/Anxious/Nervous/Nervous/Anxious/Nervous/Nervous/Nervous/Nervous/Nervous/	Diet (Special/Restricted)								N(
Tumors YES NO Dizzy Spells YES No Nervous/Anxious YES No Horvous/Anxious YES No Horvous/Anx	Artificial Joints								
Nervous/Anxious YES NO Psychiatric/ Psychological Care YES NO Psycholo	(hip, knees)							YES	N(
Do you take, or have you taken diet drug Phen-Fen or Redux?* *If yes to the above, did you have a medical exam for heart issues? Are you taking any medication for the treatment of osteoporosis or bone disease? Do you use more than two pillows to sleep? Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Do. Women: Pregnant? Yes_# months_No_Nursing? Yes No Taking birth control pills? Yes Interest and 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 should the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication.	Kidney Trouble	YES	NO	Tumors					N(
Psychological Care YES No. Do you take, or have you taken diet drug Phen-Fen or Redux?* *If yes to the above, did you have a medical exam for heart issues? YES No. Are you taking any medication for the treatment of osteoporosis or bone disease? YES No. Do you use more than two pillows to sleep? YES No. Have you lost or gained more than 10 pounds in the past year? YES No. Do you have or have you had any disease, condition, or problem not listed? YES No. Women: Pregnant? Yes # months No. Nursing? Yes No. Taking birth control pills? Yes No. Women: Pregnant? Yes # months No. Nursing? Yes No. Taking birth control pills? Yes numbered all questions to the best of my knowledge. Should further information be needed, you have my permission sk the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication.	Stroke								
Do you take, or have you taken diet drug Phen-Fen or Redux?* *If yes to the above, did you have a medical exam for heart issues? Are you taking any medication for the treatment of osteoporosis or bone disease? Do you use more than two pillows to sleep? Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Do Women: Pregnant? Yes_# months_No_Nursing? Yes No Taking birth control pills? Yes Interpretable 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 sk the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication.								YES	N(
*If yes to the above, did you have a medical exam for heart issues? Are you taking any medication for the treatment of osteoporosis or bone disease? YES M. Do you use more than two pillows to sleep? Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Women: Pregnant? Yes # months No Nursing? Yes No Taking birth control pills? Yes M. Taking birth control pil							r sychological care		111
Are you taking any medication for the treatment of osteoporosis or bone disease? Do you use more than two pillows to sleep? Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Do Women: Pregnant? Yes # months No Nursing? Yes No Taking birth control pills? Yes In the sunderstand 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 ask the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication.	5. Do you take, or have you taken diet drug Phen-Fen or Redux?*								N
Do you use more than two pillows to sleep? Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Do Women: Pregnant? Yes# months No Nursing? Yes No Taking birth control pills? Yes I will not the above information is necessary to provide me with dental care in a safe and efficient manner. I have an expective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. Date	*If yes to the above, did you have a medical exam for heart issues?								N
Do you use more than two pillows to sleep? Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Do Women: Pregnant? Yes# months No Nursing? Yes No Taking birth control pills? Yes I will not the above information is necessary to provide me with dental care in a safe and efficient manner. I have an expective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. Date									N
Have you lost or gained more than 10 pounds in the past year? Do you have or have you had any disease, condition, or problem not listed? If yes, please list: Wes, please list: Wes, please list: Wes, please list: Women: Pregnant? Yes# monthsNo Nursing? Yes No Taking birth control pills? Yes Interpretated 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 sak the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. Date Date									N
Do you have or have you had any disease, condition, or problem not listed? If yes, please list:									N
If yes, please list:									N
understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have nswered all questions to the best of my knowledge. Should further information be needed, you have my permission sk the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. Date Date								1 L5	1
nswered all questions to the best of my knowledge. Should further information be needed, you have my permission sk the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. atient/Guardian Signature	0. Women: Pregnant?	Yes	_# mon	thsNo Nursing	g? Yes	No	Taking birth control pil	ls? Yes	N
nswered all questions to the best of my knowledge. Should further information be needed, you have my permission sk the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. atient/Guardian Signature	understand the above i	nformat	tion is v	necessary to provide me	with dent	al care	in a safe and efficient m	anner I	iav
sk the respective health care provider or agency, who may release such information to you. I will notify the doctor my change in my health or medication. atient/Guardian Signature									
atient/Guardian Signature Date									
atient/Guardian Signature Date	_	_			icase sucri	ingorn	anon to you. I win noug)	ine doci	07 (
atient/Guardian Signature Date									
entist Signature Date									
	Dentist Signature						Date		