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 ○Yes ○No _____

medications containing bisphosphonates? _____

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