

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Y N If yes, explain _____
 Have you ever been hospitalized/had a major operation? Y N If yes, explain _____
 Have you ever had a serious head/neck injury? Y N If yes, explain _____
 Are you taking any medications, pills or drugs? Y N If yes, explain _____
 Do you take, or have you taken, Phen-Fen or Redux? Y N _____
 Are you on a special diet? Y N If yes, explain _____
 Do you use tobacco? Y N _____
 Do you use controlled substances? _____

Women ONLY: Are you...
 Pregnant/Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you allergic to any of the following:

Aspirin Penicillin Codeine Acrylic Metal Latex Anesthetics
 Other If other, please explain _____

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimers Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsilitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sore/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had any serious illness not listed above? Yes No
 If yes, please explain: _____

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 understand that my dental insurance carrier may pay less than the actual bill for services. I will be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. A 1.5% monthly (18% annually) service charge will be added to accounts not paid within 60 days from the date of service.

Signature of Patient, Parent, or Guardian _____ Date _____