Medical History
Patient Disclosures

Patient Name:____ Date of Last Visit:_______________

Physician Name:____ Phone:_______________

Please list all medications you are currently taking:____

Have you ever had an allergic or adverse reaction to any medication or substance? Yes No

If yes, list medication and reaction:____

Are you pregnant? Yes No Nursing? Yes No Taking birth control? Yes No

Do you have a history of the following? (Answer each item)

	YES	NO		YES	NO		YES	NO
AIDS			Diet (Special/Restricted)			Neurological Disorder		
Allergies or Hives			Emphysema			Osteoporosis Psychiatric /		
Anorexia/Bulimia			Epilepsy/Seizures			Psychological Care		
Arthritis/Rheumatism			Fainting/Dizzy Spells			Radiation Therapy		
Artificial Heart Valve			Glaucoma			Rheumatic Fever		
Artificial Joints (Hip/Knee)			Hay Fever			Sinus Trouble		
Asthma			Heart (Surgery, Disease, Attack)			Smoke/Tobacco Use		
Blood Transfusion			Heart Murmur Heart Pacemaker			STD		
Bruise Easily			Hemophilia			Stroke		
Chemotherapy			Hepatitis A, B or C			Swollen Ankles		
Chest Pain			High Blood Pressure			Thyroid Problems		
Chronic Cough			HIV Positive			Tuberculosis		
Cold Sores			Kidney Disease			Tumors/Cancer		
Congenital Heart Disease			Latex Sensitivity			TMJ Problems		
Contact Lenses			Mitral Valve Prolapse			Ulcers		
Cortisone Medication			Nervous/Anxious			Yellow Jaundice		
Diabetes								

Are you taking Coumadin, Warfarin, or any other blood thinners? Yes No

Are you taking, or have you ever taken, Bisphosphonates? (Fosamex, Boniva, etc.) Yes No

I certify that I have read and 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. I authorize and request my insurance company to pay directly to the dentist or dental group 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 dependents.

Patient / Parent / Guardian Signature: ____ Date: _______________

Dentist Signature: ____ Date: _______________