Medical History

1) Have you been under the care of a medical doctor during the past 2 years? YES NO
Physician's Name: _____ Phone #: _____

2) Please list all medications you are currently taking, including over-the-counter drugs:

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3) Are you currently using any unprescribed "street drugs?" YES NO

4) Are you ALLERGIC to any of the following? Please circle.

Aspirin	Nitrous Oxide	Valium`	Penicillin
Darvon	Erythromysin	Scopolamine	Codeine
Other Antibiotics	Local Anesthetic	Novocaine or Xylocaine	Demerol
Tetracycline	Nembutal/Seconal	Sleeping Pills	Percodan

5) Are you aware of being allergic to any other medication or substance? Please list.

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6) Have you ever had or been treated for any of the following conditions or diseases? Please circle. NONE

AIDS/ARC/HIV	Allerges or Hives	Anemia
Angina Pectoris	Arthritis	Artificial Heart Valve
Artificial Joints (hip,knee,etc.)	Asthma	Blood Transfusion (date)
Bruise Easily	Chemotherapy (Cancer,Leukemia)	Cancer
Congenital Heart Lesions	Cold Sores or Fever Blisters	Cortisone Medication
Diabetes	Dizziness	Drug Addiction
Emphysema	Epilepsy	Excessive Bleeding
Glaucoma	Hay Fever	Heart Failure
Heart Disease or Attack	Heart Murmur	Heart Surgery
Hemophilia	Hepatitis (A-infectious,B-serum)	Herpes
High Blood Pressure	Kidney Disease	Liver Disease
Low Blood Pressure	Mitro Valve Prolapse	Nervous Disorders
Psychiatric Treatment	Rheumatic Fever	Scarlet Fever
Scarlatina	Shortness of Breath	Sickle Cell Disease
Sinus Problems	Stroke	Thyroid Disease
Tuberculosis	Tumor	Ulcers
X-ray or Cobalt Treatment	STD (sexually transmitted disease)	Anorexia/Bulimia

7) Do you have any disease, condition, or problem not listed? If yes please explain.

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8) For women only: Is there any possibility that you are pregnant? YES NO
If YES, what is your due date? _____ Are you nursing? YES NO
Are you taking birth control pills? YES NO

9) Do you have any sores in your mouth or on other areas of your body? YES NO

10) Have you had any sores in or around your mouth or on any other areas of your body in the past which return occasionally? YES NO

11) Do you use tobacco products? YES NO
If so, how much? _____ What form? _____

CONSENT:

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, any other diagnostic aids deemed appropriate by the doctor, in consultation with me, to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor, in consultation with me, to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____, and further authorize and consent that the doctor choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.75% finance charge (21% annually) will be added to the balance over 60 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient: _____ Date: _____ Witness: _____

Parent or Guardian Signature: _____ Relationship to Patient: _____