

Date \_\_\_\_\_ Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Have there been changes in your address, telephone numbers, insurance or employment since your last visit?  Yes  No

Please specify \_\_\_\_\_

Special concerns for today's visit \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Pharmacy \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

- |  |   |  |
|--|---|--|
| AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No                        | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No      | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No                      | HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No             | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No       | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No               | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No           | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No            |  |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No         | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No       |  |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No                | Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No         |  |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No        | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No         |  |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No        | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |
| Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No            |  |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |
| Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No            |  |
| Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No       | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No                |  |
| Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Special Diet/Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No                   |  |
| Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No              | Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No        | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |
| Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No         |  |

**Have you ever had or been diagnosed with:**

- Artificial Heart Valves  Yes  No
- Artificial Joints, Screws, Pins, etc.  Yes  No
- Bleeding abnormally, with extractions or surgery  Yes  No
- Blood Disease  Yes  No
- Congenital Heart Lesions  Yes  No
- Heart Murmur  Yes  No
- Hernia Repair  Yes  No
- Mitral Valve Prolapse  Yes  No
- Pacemaker  Yes  No
- Rheumatic Fever  Yes  No

**Are you allergic to:**

- Aspirin  Yes  No
- Barbiturates  Yes  No
- Codeine  Yes  No
- Ibuprofen  Yes  No
- Latex  Yes  No
- Local Anesthesia  Yes  No
- Metals (i.e. gold)  Yes  No
- Penicillin  Yes  No
- Other \_\_\_\_\_

**Have you ever had any complications following dental treatment?**  Yes  No

If yes, please describe \_\_\_\_\_

**Have you ever been hospitalized or do you have any other health concerns?**  Yes  No

If yes, please describe \_\_\_\_\_

**Have you ever taken any of these medications?**

- Blood Thinners  Yes  No
- Coumadin  Yes  No
- Warfarin  Yes  No
- Diet Medications  Yes  No
- Dexfenfluramine  Yes  No
- Fen-phen  Yes  No
- Pondimin  Yes  No
- Redux  Yes  No
- Levoxyl  Yes  No
- Synthroid  Yes  No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

**Please PRINT all medications now taking:** \_\_\_\_\_

**CERTIFICATION AND ASSIGNMENT**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ Name of Insurance Company(ies) and assign directly to

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to \_\_\_\_\_ Date \_\_\_\_\_

Results \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_