MEDICAL/DENTAL HISTORY

Physicians Name_____Date of Last Physical_____

Name of Last Dentist_____Date of Last exam_____

Purpose of today's visit ___complete exam/cleaning ____pain ____broken tooth

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

___Heart Disease
___High Blood Pressure
___Blood Disorder-Anemia
___Rheumatic Fever
___Heart Murmur
___Thyroid Disease, Hyperthyroidism
___Diabetes
___Stroke
___Epilepsy
___Fainting
___Psychiatric Treatment
___Sinus Trouble
___Ulcers
___Liver or Kidney Disease
___Hepatitis, Jaundice
___HIV/AIDS
___Tuberculosis, Emphysema
___Asthma
___Arthritis
___Radiation Treatment
___Tumor History
___Do You Smoke?
___Are You Pregnant?

Are you allergic to Penicillin or any other antibiotics?_____
If so, please list_____
Are you allergic to Codeine or aspirin?_____
Are you allergic to local anesthetics like Novacaine?_____
Are you allergic to latex?_____
Do you have any other allergies not listed above?_____
If so, please list_____
Have you had a) your wisdom teeth removed?_____If so, when_____
b) braces?_____ If so, when_____
c) periodontal surgery?_____If so, when?_____

Please list all medications you are taking_____
_____

Do you have any medical problem not listed above that we should know about?_____
_____

Are you satisfied with your smile?
A) Teeth Alignment?_____
B) Teeth Color?_____
C) Are you concerned with your breath?_____

CONSENT

I Consent to treatment as deemed necessary for the above named patient, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his assistant or qualified designate. The above information is true and accurate. I acknowledge full responsibility for the payment of such service and agree to pay for them in full, according to the arrangements made with the business office.

Signed _____Date_____