

Health History

Have you had a serious illness, surgery or been hospitalized in the past 5 years? _____

If so, what was the problem? _____

Date of last medical ck-up _____ Are you under a physician's care now? _____ Reason: _____

What prescription medications do you take? (*Include birth control as antibiotics interfere.*)

Do you currently or have you ever had any of the following:

Do you get mouth sores, cold sores, canker sores or fever blisters? Yes or No

Yes	No		Yes	No
		Rheumatic fever		
		Rheumatic heart disease		
		Jaundice		
		Heart Disease		
		Heart attack		
		High blood pressure		
		Stroke		
		Chest Pain		
		Shortness of breath		
		Swollen ankles		
		Blood disorders		
		Anemia		
		Blood test w/unusual result		
		Abnormal bleeding		
		Prolonged healing		
		Bruise easily		
		Asthma, hay fever		
		Are you pregnant?		
		Liver disease		
		Hepatitis		
		Kidney disease		
		Arthritis		
		Tuberculosis		
		Lung ailments		
		Persistent Cough		
		Cough up Blood		
		Diabetes		
		Radiation for tumor		
		Allergic to Penicillin		
		Allergic to Aspirin		
		Allergic to Latex		
		Artificial heart valves		
		Artificial joints		
		Cancer		

*** I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician.**

*** I give permission for my dentist and his clinical team to make any necessary diagnostic photos or study models to enable complete diagnosis and treatment.**

*** I additionally authorize the release of medical information to insurance companies for legal documentation.**

*** I understand that my insurance is an agreement between my insurance company and me, and that I am responsible for my balance regardless of my insurance.**

*** I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.**

Signature: _____ Date:

*** I have read, agreed to, and understand the statements listed above.**

(If patient is a minor then Parent or Guardian must sign)