Medical History

Physician: _____

List all medications you are taking: _____

Allergies: _____

Are you pregnant?_____ Yes ____ No Taking birth control pills? _____ Yes _____ No

Do you have a history of the following?

__ Anemia	__ Cancer	__ Epilepsy	__ Kidney Disease
__ Arthritis	__ Chemical Dependency	__ Heart Murmur	__ Liver Disease
__ Artificial Heart Valves	__ Chemotherapy	__ Heart Surgery*	__ Radiation Treatment
__ Artificial Joints	__ Circulatory Problems	__ Hemophilia	__ Shortness of Breath
__ Blood Disease	__ Cortisone Treatments	__ Hepatitis	__ Stroke
__ Bone Diseases	__ Diabetes	__ High Blood Pressure	__ Tobacco Habit
__ Bone Strengtheners	__ Endocarditics	__ HIV Positive	__ Ulcer

*Heart Surgery Describe _____

Any additional conditions and/or treatments not previously indicated: _____

_____

_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis, and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. 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. If my account becomes delinquent I am responsible for all banking and legal fees including a 50% collection fee.

X _____

Signature of Patient (or Parent, if a minor) **Date**

HEALTH HISTORY REVIEWED	_____ Patient Initial	_____ Date	_____ Doctors Initial
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