Medical History

Physician's name _____ *Date of last visit* _____
*Previous hospitalizations, illnesses, or operations (please describe and give an approximate date)*_____
_____

Have you ever had a blood transfusion? ___*yes*___ *no if yes, please give an approximate date*_____

Women are you pregnant ___*yes* ___ *no Nursing* ___*yes* ___ *no Taking birth control pills* ___*yes* ___ *no*

Please check if you've had or have any of the following:

YES	NO		YES	NO		YES	NO	
___	___	AIDS	___	___	Epilepsy	___	___	Pacemaker
___	___	Anemia	___	___	Fainting	___	___	Psychiatric care
___	___	Arthritis	___	___	Glaucoma	___	___	Radiation treatment
___	___	Artificial heart valves	___	___	Headaches	___	___	Respiratory disease
___	___	Artificial joints	___	___	Heart murmur	___	___	Rheumatic fever
___	___	Asthma	___	___	Heart problems	___	___	Scarlet fever
___	___	Back problems			describe _____	___	___	Shortness of breath
___	___	Blood disease	___	___	Hemophilia	___	___	Skin rash
___	___	Cancer	___	___	Hepatitis	___	___	Swelling of feet
___	___	Chemical dependency	___	___	High blood pressure	___	___	Thyroid problems
___	___	Chemotherapy	___	___	HIV positive	___	___	Tobacco habit
___	___	Circulatory problems	___	___	Jaw pain	___	___	Tonsillitis
___	___	Cortisone treatments	___	___	Kidney disease	___	___	Tuberculosis
___	___	Cough, persistent	___	___	Liver disease	___	___	Ulcer
___	___	Cough up blood	___	___	Mitral valve prolapse	___	___	Venereal disease
___	___	Diabetes	___	___	Nervous problems	___	___	Stroke

Please list any medications you are currently taking _____
Please list any allergies _____

AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

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

Signature _____ *Date* _____

Payment is due at time of treatment, unless prior arrangements have been approved.