

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Address \_\_\_\_\_

4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs or pills? ..... YES NO  
 If yes, please list: \_\_\_\_\_
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO  
 If yes, please list: \_\_\_\_\_

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure .....	YES	NO	Artificial Joints (hip, knee, etc.) .....	YES	NO	Hepatitis B (serum) .....	YES	NO
Heart Disease or Attack .....	YES	NO	Kidney Trouble .....	YES	NO	Venereal Disease .....	YES	NO
Angina Pectoris .....	YES	NO	Ulcers .....	YES	NO	A.I.D.S. ....	YES	NO
Congenital Heart Disease .....	YES	NO	Diabetes .....	YES	NO	H.I.V. Positive .....	YES	NO
Heart Murmur .....	YES	NO	Thyroid Problems .....	YES	NO	Cold Sores/Fever Blisters .....	YES	NO
High Blood Pressure .....	YES	NO	Glaucoma .....	YES	NO	Blood Transfusion .....	YES	NO
Arteriosclerosis .....	YES	NO	Cosmetic Surgery .....	YES	NO	Hemophilia .....	YES	NO
Mitral Valve Prolapse .....	YES	NO	Emphysema .....	YES	NO	Anemia .....	YES	NO
Artificial Heart Valve .....	YES	NO	Chronic Cough .....	YES	NO	Sickle Cell Disease .....	YES	NO
Heart Pacemaker .....	YES	NO	Tuberculosis .....	YES	NO	Bruise Easily .....	YES	NO
Heart Surgery .....	YES	NO	Asthma .....	YES	NO	Liver Disease .....	YES	NO
Rheumatic Fever .....	YES	NO	Hay Fever .....	YES	NO	Yellow Jaundice .....	YES	NO
Arthritis .....	YES	NO	Allergies or Hives .....	YES	NO	Epilepsy or Seizures .....	YES	NO
Rheumatism .....	YES	NO	Sinus Trouble .....	YES	NO	Fainting or Dizzy Spells .....	YES	NO
Cortisone Medicine .....	YES	NO	Radiation Therapy .....	YES	NO	Nervousness .....	YES	NO
Drug Addiction .....	YES	NO	Chemotherapy .....	YES	NO	Psychiatric Treatment .....	YES	NO
Stroke .....	YES	NO	Hepatitis A (infectious) .....	YES	NO	Developmentally Disabled .....	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the last year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

If yes, please list: \_\_\_\_\_

**FOR WOMEN ONLY:**

Are you pregnant?  Yes, what month? \_\_\_\_\_  No Are you nursing?  Yes  No Are you taking birth control pills?  Yes  No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

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

**CONSENT:**

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. A 35% charge will be added to all delinquent accounts sent to collections.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_