Medical Information

Patient's Name_____

Physician's Name_____ Phone_____

Date of last visit_____ Have you had any serious illnesses or operations? __Y __N

If yes, describe_____

Check yes or no whether you have had any of the following:

Y	N		Y	N		Y	N	
		Aids/HIV Positive			Epilepsy			Psychiatric Care
		Anaphylaxis			Fainting			Rapid weight gain or loss
		Anemia			Food Allergies			Radiation Treatment
		Arthritis			Glaucoma			Respiratory Disease
		Artificial Heart Valves			Headaches			Rheumatic/Scarlet Fever
		Artificial Joint *(hip, knee replacement)*			Heart Murmur			Shingles
		Asthma			Heart Problems *(stent, murmur, pacemaker, heart attack)*			Shortness of Breath
		Atopic (allergy prone)			Hemophilia			Skin Rash
		Back Problems			Herpes			Spina Bifida
		Blood Disease			Hepatitis			Stroke
		Cancer			High Blood Pressure			Surgical Implant
		Chemical Dependency			Jaw Pain			Swelling of feet or ankles
		Chemotherapy			Kidney Disease			Thyroid Disease
		Circulatory Problems			Liver Disease			Tobacco Habit
		Cortisone Treatments			Material Allergies *(latex, wool, metal, chemicals)*			Tonsillitis
		Cough, persistent			Mitral Valve Prolapse			Tuberculosis
		Cough up blood			Nervous Problems			Ulcer/Colitis
		Diabetes			Pacemaker/Heart Surgery			Venereal Disease

Is patient currently taking any medications? __Y __N If yes, list all:

_____

Does patient have any drug allergies? __Y __N If yes, list all:

_____

Women: Are you pregnant? __Y __N Nursing? __Y __N

Taking birth control pills? __Y __N

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

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