Patient's Medical History

Patient's Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Have you ever had a serious head or neck injury? N Y if Yes, _____
Have you ever taken Fosamax, Boniva, Prolia or
any other medications containing bisphosphonates? N Y if Yes, _____
Do you use chewing Tobacco or do you smoke? N Y if Yes, _____
Do you use controlled substances? How often? N Y if Yes, _____
Have you ever been hospitalized or had a major
operation including joint replacement? N Y if Yes, _____
HAVE YOU BEEN INSTRUCTED TO TAKE AN
ANITBIOTIC PRIOR TO DENTAL APPOINTMENTS? N Y If Yes, _____
Please list all medications, prescription, and over the counter, and reason for taking : _____

_____

Women: Are you __ Pregnant or Trying to get pregnant? __ Nursing? __ Taking oral contraceptives?
Are you allergic to any of the following? __ Aspirin __ Penicillin __ Codeine __Latex __Local Anesthetics __ Metal
__ Sulfa Drugs Other allergies? _____
Do you have, or have you had, any of the following? Please Circle if YES

AIDS/HIV Positive	Excessive Thirst	Mitral Valve Prolapse
Alcohol Addiction	Fainting Spells/Dizziness	Mitral Valve Replacement
Alzheimer's Disease	Frequent Headaches	Osteoporosis
Anaphylaxis	Glaucoma	Pain in Jaw Joints
Anemia	Heart Attack	Parathyroid Disease
Angina/Chest Pain	Heart Murmur	Psychiatric Care
Artificial Heart Valve	Heart Pacemaker	Radiation Treatments
Artificial Joint	Heart Disease	Renal Dialysis
Asthma	Hemophilia	Rheumatic Fever
Autoimmune Disease	Hepatitis A	Seasonal Allergies
Blood Transfusion	Hepatitis B	Shingles
Breathing Problems	Hepatitis C	Sickle Cell Disease
Cancer	High Blood Pressure	Sinus Trouble
Chemotherapy	High Cholesterol	Spina Bifida
Cold Sores/Herpes	Frequent Cough	Stroke
Congenital Heart Disorder	HPV	Thyroid Disease
Cortisone/Steroid Use	Hypoglycemia	Tonsillitis
Diabetes	Irregular heartbeat	Tuberculosis
Drug Addiction	Kidney Problems	Tumors or Growths
Dry Mouth	Leukemia	Ulcers
Emphysema	Liver Disease	Venereal Disease
Epilepsy/Seizures	Low Blood Pressure	
Excessive Bleeding	Lung Disease	

Have you ever had any serious illness not listed above? NO YES If yes, please specify _____

_____

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 or dental group insurance benefits otherwise payable to me. 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. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____

Signature of Patient, Parent or Guardian Date