

Health History

Patient Name: _____

Indicate which of the following you have had or have at the present? Please check those that apply:

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____		
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Fever blisters	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to metal (jewelry, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Rods or Pins	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Codeine Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone medication	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis medications		
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fosomax or	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>	Bonine	<input type="checkbox"/>	<input type="checkbox"/>
or Dialysis			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Others Not Listed	<input type="checkbox"/>	<input type="checkbox"/>
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Embolism	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>			

When was your last Dental Exam? _____

When was your last full mouth x-rays? _____

Have you had to take **antibiotics** before any dental treatment? Yes No If so why? _____

Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

Are you sensitive or allergic to any medication or anesthetics? Yes No If yes, please list: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

Are you now under the care of a physician? Yes No If yes, please explain: _____
Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

List all medications you are currently taking: _____

Have you ever taken appetite suppressants - fen-phen (Fenluramine & Phentermine) or dexenfluramine? Yes No

Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? Yes No If yes, Physicians Name: _____ Phone#: _____

For Women Only: Are you taking birth control? Yes No If yes, patient has to seek other methods of contraceptives while Taking antibiotics, or risk pregnancy.

1. The undersigned hereby authorizes doctor to order 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. 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 all recommended treatment.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Appointment Policy

We make every attempt to schedule appointments for our patients in a manner that reduces any waiting time and provide prompt and attentive service to each and every patient. We make every effort to be ready for you at your scheduled appointment time. We expect our patients to respect their scheduled appointment times and make every effort to be on time.

We do require 48-hour notice for any appointment change. Failure to do so could result in a broken appointment charge. A broken appointment is a loss to you and prevents us from providing you with needed preventive and restorative care. It is a loss to the patient who could have had that appointment time. And it is a loss to our team who was fully prepared for your visit.

Keeping your scheduled appointments and being on time is an important part of what contributes to our team providing the care our patients are accustomed to. We realize changes may need to be made occasionally, but we respectfully ask for your attention to this matter.

Signature of patient, parent or guardian

Date: _____