

Medical Information

Are you having pain or discomfort at this time?.....Yes No
Have you been a patient in the hospital during the last two years?.....Yes No
Are you now taking any medications or drugs?.....Yes No

If yes please list:

Have you taken any medications or drugs during the past two years?.....Yes No
Have you take appetite suppressants fen-phen (fenfluramine and phentermine) or dexfenfluramine or fenfluramine?.....Yes No

Have you been under the care of medical doctor during the last two years or since taking any of the appetite suppressants named above?.....Yes No

Physician's name.....Yes No

Phone..... () -

Address.....

Are you sensitive or allergic to any medications or anesthetics?.....Yes No

If yes please list:

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

- | | | |
|--|-------------------------------|---|
| Heart Failure.....Yes No | Diabetes.....Yes No | Developmentally Disabled.....Yes No |
| Heart disease or attack.....Yes No | Thyroid Problems.....Yes No | Allergy to Metal (jewelry, etc.).....Yes No |
| Angina Pectoris.....Yes No | Glaucoma.....Yes No | Tumors.....Yes No |
| Artificial joints (hip, knee, etc.).....Yes No | Cancer.....Yes No | Epilepsy or dizzy spells.....Yes No |
| Kidney Trouble.....Yes No | Emphysema.....Yes No | Cold Sores/Fever Blisters.....Yes No |
| Ulcers.....Yes No | Chronic Cough.....Yes No | Liver Disease.....Yes No |
| Congenital Heart Disease.....Yes No | Tuberculosis.....Yes No | Bruise Easily.....Yes No |
| Heart Murmur.....Yes No | Asthma.....Yes No | Sickle Cell Disease.....Yes No |
| High Blood Pressure.....Yes No | Hay Fever.....Yes No | Hemophilia.....Yes No |
| Arteriosclerosis.....Yes No | Allergies or Hives.....Yes No | Anemia.....Yes No |
| Mitral Valve Prolapse.....Yes No | Sinus Trouble.....Yes No | Blood transfusion.....Yes No |
| Artificial Heart Valve.....Yes No | Radiation Therapy.....Yes No | Allergy to Latex.....Yes No |
| Heart Surgery.....Yes No | Chemotherapy.....Yes No | Yellow Jaundice.....Yes No |
| Rheumatic Fever.....Yes No | Nervousness.....Yes No | Stroke.....Yes No |
| Arthritis.....Yes No | Osteoporosis.....Yes No | H.I.V. Positive.....Yes No |
| Rheumatism.....Yes No | Veneral Disease.....Yes No | Drug Addiction.....Yes No |
| Cortisone Medicine.....Yes No | A.I.D.s.....Yes No | |

Hepatitis.....Yes No

if yes, which strain? A B C

When you walk upstairs 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

Do your ankles swell during the day?.....Yes No

Do you use more than two pillows to sleep?.....Yes No

Have you lost or Gained more than ten pounds in the past year?.....Yes No

Do you ever wake up from sleep and feel short of breath?.....Yes No

Are you on a special diet?.....Yes No

Do you have or have you had any diseases , condition, or problem not listed?.....Yes No

If yes, please list:

For Women Only: Are you pregnant? Yes No Yes, What Month? _____ Are You Nursing? Yes No

Are you Taking birth control pills?

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: 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 patients needs .

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 to provide recommended treatment. 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) and statement fee may be added to my account, in addition to any collections charges. I understand that where appropriate, credit bureau reports may be obtained. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form. I authorize the use of my social security number to file my dental claim. **There will be a \$25.00 charge for missed appointments without 24 hours notice.**

Reviewed by: _____ Date: _____