HEALTH INFORMATION

Medical Physician _____ Office Phone _____ Last Visit _____
Are you under medical care now? (If so, please describe) _____
_____
Please list any medications you are taking (including non prescription) _____
_____
Do you use tobacco products? (Re: cigarettes, smokeless tobacco) _____

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medicines and treatments are best for you. **(Be sure to fill chart out completely.)**
★ If you have any of the starred conditions, please call the office prior to your appointment... Pre medication may be required.

Yes	No		Yes	No	
		Diabetes			Organ Transplant ★
		Kidney Dialysis ★			Joint Replacement ★ or Implant ★
		Rheumatic Fever ★			Radiation Treatment
		Heart Murmur ★			Stroke
		Valve Disorders ★			Anemia
		Heart Trouble, Heart Attack			Frequently Tired or Easily Winded
		Heart Disease			Liver Disease
		Cardiac Pacemaker			Ulcers, Stomach or Mouth
		High or Low Blood Pressure (Please specify)			Respiratory Problems, Tuberculosis
		Asthma			Eye or Ear Problems
		Hepatitis (Specify A, B or C) Year:			Epilepsy or Seizures
		Frequent Illness, Lowered Immunity			Venereal Disease, any type
		Bleeding Disorder, Hemophilia			Unusual Weight Loss or Gain
		Blood Transfusions Reason:			HIV + or AIDS
		Cancer, Tumors, Cysts			Other

Allergies (Please answer yes or no- do not leave blank):
Are You Allergic To Penicillin? _____ Local Anesthetics? _____ Aspirin? _____ Iodine? _____ Codeine? _____
Sulfa Drugs? _____ Latex Rubber? _____ Please list any other allergies to medication: _____

Is there any other health information we should know? _____
Are You Pregnant? _____ Due Date: _____ Nursing? _____ Oral Contraceptives? _____ **(Please inform us if you become pregnant.)**
Please inform us if your health information should change.
Whom should we contact in case of an emergency? **(Please do not leave this blank)**
Name: _____ Phone? _____ Relationship? _____
Closest relative or friend not living with you? _____ Phone: _____

To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.

_____ Date: _____
Signature of patient (or parent if patient is a minor)

★OFFICE USE ONLY★

Reviewed By Dentist: _____ **Date:** _____

MEDICAL UPDATES (to be filled out at future appointments)

DATE	PATIENT'S/ GUARDIAN'S SIGNATURE	CHANGES IN MEDICAL HISTORY	Doctor's Initials