Medical History

Physician's Name _____ Address _____ Phone_____

Date of Last visit _____ Have you had any Serious Illnesses or Operation? ☐ Yes ☐ No If yes, describe ____

Current medication ☐Yes ☐No If yes, what? _____

Current treatment ☐Yes ☐No If yes, what? _____

Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Sulfa drugs ☐ Others _____ ☐ No

Are you allergic to Latex ☐Yes ☐No Phen-Fen taken ☐Yes ☐No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Do you have , or have you had any of the following: (please circle **Y** for yes, **N** for No)

Y/N Anemia	Y/N Asthma or Hay Fever	Y/N Allergies
Y/N Blood diseases	Y/N Diabetes	Y/N Epilepsy
Y/N Excessive Bleeding	Y/N Glaucoma	Y/N High Blood Pressure
Y/N HIV/AIDS	Y/N Heart Ailments	Y/N Hepatitis or Liver Disease
Y/N Kidney Disease	Y/N Nervous Disorders	Y/N Radiation Treatment
Y/N Respiratory Disease	Y/N Rheumatic Fever	Y/N Rheumatism or Arthritis
Y/N Stomach Ulcers	Y/N Seizures	Y/N Sinus Trouble
Y/N Thyroid Disease	Y/N Tuberculosis	Y/N Tumors or Growths

Do you have any disease or problem not listed that you think we should know about? ☐Yes ☐No

If yes, what? _____

Date _____ Signature _____

Year 2 Changes in Health _____

Date _____ Signature _____

Year 3 Changes in Health _____

Date _____ Signature _____

Year 4 Changes in Health _____

Date _____ Signature _____

Health Questionnaire MUST be up dated every year!

	Year 1	Year 2	Year 3	Year 4
Date				
BP				
Pulse				
By				

DO NOT WRITE IN THIS SPACE

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedatin; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this aptient.

I have been informed of all possible complications of the procedures, anesthetics and/ or drugs.

Signed: _____ Date: _____

Authorization must be signed by the Patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

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 healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group 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 _____