

4b

MEDICAL HISTORY

Your Current Physical Condition ☐ Good ☐ Fair ☐ Poor
 Do you use tobacco in any form? ☐ Yes ☐ No
 Are you taking any over-the-counter/prescription or
 herbal supplement drugs? ☐ Yes ☐ No
 Please List Each One _____

Have you ever taken Phen-Fen? ☐ Yes ☐ No
 (Also known as Redux or Pondimin) If yes, when? _____
 Have you ever taken any bone density medications?
 (Fosamax, etc.) ☐ Yes ☐ No If yes, when? _____
 Has your doctor ever told you that you require
 antibiotics prior to dental treatment? ☐ Yes ☐ No

FOR WOMEN ONLY

Are you taking birth control medications? ☐ Y ☐ N
 Are you pregnant? ☐ Yes ☐ No Week # _____
 Are you nursing? ☐ Yes ☐ No

 HAVE YOU EVER HAD ANY
 OF THE FOLLOWING DISEASES
 OR MEDICAL PROBLEMS?

Yes No	Abnormal Bleeding	Yes No	Cold Sores/Fever Blisters
Yes No	Drug/Alcohol Abuse	Yes No	High Blood Pressure
Yes No	Anemia	Yes No	HIV / AIDS
Yes No	Arthritis	Yes No	Hospitalized for
Yes No	Artificial Bones, Joints		any reason
	or Valves	Yes No	Kidney Problems
Yes No	Asthma	Yes No	Liver Disease
Yes No	Blood Transfusion	Yes No	Low Blood Pressure
Yes No	Cancer/Chemotherapy	Yes No	Lupus
Yes No	Colitis	Yes No	Mitral Valve Prolapse
Yes No	Congenital Heart Defect	Yes No	Pacemaker
Yes No	Diabetes	Yes No	Psychiatric Problems
Yes No	Difficulty Breathing	Yes No	Radiation Treatment
Yes No	Emphysema	Yes No	Rheumatic/
Yes No	Epilepsy		Scarlet Fever
Yes No	Fainting Spells	Yes No	Seizures
Yes No	Frequent Headaches	Yes No	Shingles
Yes No	Glaucoma	Yes No	Sickle Cell Disease
Yes No	Hay Fever	Yes No	Sinus Problems
Yes No	Heart Attack	Yes No	Stroke
Yes No	Heart Murmur	Yes No	Thyroid Problems
Yes No	Heart Surgery	Yes No	Tuberculosis (TB)
Yes No	Hemophilia	Yes No	Ulcers
Yes No	Hepatitis	Yes No	Veneral Disease

Please list any other medical condition(s) that you have had:

 ARE YOU ALLERGIC TO
 ANY OF THE FOLLOWING?

Yes No	Aspirin	Yes No	Erythromycin	Yes No	Penicillin
Yes No	Codeine	Yes No	Jewelry/Metals	Yes No	Tetracycline
Yes No	Dental Anesthetics	Yes No	Latex	Yes No	Other

Please list any other drugs/materials that you are allergic to:

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DISCLAIMER

For the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. The undersigned hereby authorizes Doctor, in order to make a thorough diagnosis of the patient's dental needs, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor. I understand that the Doctor will advise me of any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____.

I also understand that the Doctor may choose and employ such assistance as deemed fit. I further understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time that services are rendered unless financial arrangements have been previously made. I further understand that I am entitled to a 5% courtesy if payment for services is made within 24 hours. All other financial arrangements, insurance, credit cards, or time payments, are not subject to that courtesy. A 1 1/2 % monthly finance charge will be applied to all accounts over 60 days past due. There will be a \$25.00 service charge on all returned checks. We require 24 hours notice for cancellations. If a 24 hour notice is not given, it will be necessary to charge \$30.00 for each appointment cancelled. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature

Date

PAYMENT IS DUE IN FULL AT TIME OF
 TREATMENT UNLESS PRIOR ARRANGEMENTS
 HAVE BEEN APPROVED



Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____
 Doctor's comments _____