## *Medical history*

Physician s Name _____ Address _____Phone _____
Are you under medical treatment now? Y N Reason_____
Have you been hospitalized during the past 5 years? Please explain _____

Please circle any substance you are allergic to
Local anesthetics (Lidocaine), Penicillin, Erythromycin, Codeine, Sulfa Drugs, Barbiturates, Aspirin, Nickel or Mercury, Latex
Other _____

| | | |
|---|---|---|
| Asthma | Y | N |
| Anemia | Y | N |
| Clotting Problems | Y | N |
| Other blood disorders | Y | N |
| Please specify_____ | | |
| Chest pain, ankle swelling, shortness of breath | Y | N |
| Diabetes | Y | N |
| Epilepsy | Y | N |
| Fainting | Y | N |
| Glandular disease (thyroid, salivary, etc.) | Y | N |
| Kidney disease | Y | N |
| Liver disease, Hepatitis, Jaundice | Y | N |
| Tuberculosis | Y | N |
| Lung Disease | Y | N |
| Stomach or Duodenal Ulcers | Y | N |
| Tumor history | Y | N |
| Rheumatoid Arthritis history | Y | N |

| | | |
|---|---|---|
| Heart Disease | Y | N |
| Heart Murmur | Y | N |
| Have you had Rheumatic Fever? | Y | N |
| Have you had a Stroke in the past 10 yrs? | Y | N |
| Do you have a pacemaker? | Y | N |
| Joint replacement or Implant | Y | N |
| High Blood Pressure | Y | N |
| Low Blood Pressure | Y | N |
| Radiation treatment | Y | N |
| Venereal Disease | Y | N |
| A.I.D.S / HIV + | Y | N |
| Psychiatric treatment | Y | N |
| Are you pregnant? | Y | N |
| Have you taken Phen-Fen or Redux | Y | N |
| Do you use any recreational substances? | Y | N |
| Do you smoke cigarettes? | Y | N |
| Do you drink alcohol? | Y | N |

List other medical condition not listed above
_____
List all medications you are taking, include vitamins, aspirins, etc _____

Please describe any unfavorable experiences during previous dental treatment:
_____

Do you require pre-medication, such as antibiotics or sedatives, prior to dental treatment? Y N
If yes, what medication do you take? _____

### *Acknowledgement and Consent*

I consent to treatment necessary for the patient named above, including but not limited to any medications such as anesthetics, antibiotics, antiseptics, x-rays, and laboratory work that may be used by the attending doctor, or his or her assistants. I authorize my dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I also acknowledge full responsibility for the payment of such services and agree to pay in full the portion not covered by my insurance, at the time of service, unless financial agreement is made prior to service. Unless I have prepaid for my services to treatment, the Solano Dental Group may request a credit report on me and/or my guarantor.

Signed _____ Date_____
Patient, Parent, or Guardian (must be 18 years or older)

Reviewed By Dr._____ Date_____