

Other Information

Physician's Name _____ Physician's Phone _____

Have you had a serious illness or operation? Y N

If yes, please describe _____

Are you currently under physician care? Y N

If yes, please describe _____

Medical History and Information: Please check those conditions that have ever applied to you

Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve**
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect**
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids
- Heart Attack**

- Joint Replacement**
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever**
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Erythromycin
- Latex
- Metals
- Penicillin

Other Allergies: _____

Y N
 Do you Smoke or use Tobacco?

Women Only

Y N
 Are you taking Birth Control Pills?
 Are you pregnant? If yes, # of weeks _____
 Are you nursing?

Please list any medications you are currently taking:

Have you EVER taken any bisphosphonates? (e.g. Fosomax, Actonel) Y N

Treatment Authorization

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

PATIENT OR PARENT/GUARDIAN PRINT NAME

DATE

PATIENT OR PARENT/GUARDIAN SIGNATURE