Medical History

Circle any of the following which you may have at the present time:

Heart Condition	Anemia or Hemophilia	Asthma or Hay Fever	Blood Transfusion	Cancer or Tumor
Heart Attack or Stroke	Bruise Easily	Skin Rashes or Hives	Thyroid Disease	Radiation/ Chemo
Heart Murmur	Shortness of Breath	Kidney Trouble	Cotisone Medicon	HIV/AIDS
Heart Surgery	Swelling of Ankles	Diabetes	Arthritis or Rheumatism	Venereal Disease
Artificial Heart Valve*	Artificial Joint*	Sickle Cell Disease	Pain in Jaw Joints/TMJ	Cold Sores
Heart Pacemaker*	Lung Disease	Liver Disease	Fainting or Dizzy Spells	Epilepsy/Seizure
High Blood Pressure	Emphysema	Hepatitis A, B, C, D	Glaucoma	Mental Health TX.
Rheumatic Fever*	Tuberculosis (T.B.)	Yellow Jaundice	Alcohol/Drug Addiction	

List any diseases, conditions or problems not shown above.____

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List any medicine or drugs you are currently taking.____

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Are you ALLERGIC to any medicine, drug, or other substance?............Yes No

If yes please list____

Have you taken medication for treatment of Osteoporosis? Yes No
Are you currently being treated by a physician? Yes No
Have you ever been hospitalized or had surgery? Yes No
Have you ever had a reaction to local anesthesia? Yes No
Have you ever had prolonged bleeding? Yes No
Have you ever had complications following dental treatment? Yes No
Have you ever had injury or trauma to your face? Yes No
Are you required to take premedication prior to dental treatment? Yes No
Would you like to have Nitrous Oxide sedation(available for an additional fee?) Yes No

WOMEN:
Are you pregnant now? Yes No
Are you practicing birth control? Yes No
Are you breast feeding? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health; or if my medications change, I will inform the doctor at the next appointment with out fail. **I ACCEPT FULL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY Dr.** . I understand payment is expected at the time of services are rendered. I understand that insurance coverage is a contractual arrangement between myself and my insurance company. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all costs of collection including but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on behalf and also authorizes payment sent directly to Dr. .

Date:

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Signature of Patient, Parent or Guarantor