Medical History:

Date of last medical exam__________Dr's Name________________________________
Phone #_______________________Are you currently under Dr's Care______________
Pharmacy:______________________Pharmacy Phone #:__________________________
Serious Illnesses or operations____
Women: Are you Pregnant_______ Nursing_________On Fen-Phen/Redux____________
Please check all that apply:

___Aids/HIV	___Cough, Persistent	___Jaw Pain	___Shingles
___Anaphylaxis	___Cough up blood	___Kidney Disease	___ Short of Breath
___Anemia	___Diabetes	___Liver Disease	___Stroke
___Arthritis	___Epilepsy	___Allergies	___Surgical Implants
___Artificial Joints	___Fainting	___MVP	___Swelling Feet
___Artificial Heart Valves	___Food Allergies	___Nervous Prob.	___Thyroid Disease
	___Glaucoma	___Pacemaker	___Tobacco Habit
___Back Problems	___Heart Murmur	___Psychiatric care	___Tonsillits
___Blood Disease	___Heart Problems	___HBP	___Ulcers
___Cancer	___Herpes	___Rapid weight loss or gain	___Respiratory Dise.
___Chemical Depend.	___Hepatitis		___MentalDisorders
___Slow Healing	___Pre-Medications	___Sinus Problems	___Neck Pain
___Taking Blood Thinners			

Have you had a reaction to any dental anesthetics? If yes – what occurred.
Are you taking any types of blood thinners? Yes or No: ______

Are you currently taking any medications? List all of them.

_______________________________ ____
_______________________________ ____
_______________________________ ____
_______________________________ ____

Do you have any allergies? __________ Please List them.

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I have reviewed the information and it is accurate to the best of my knowledge. I understand that the information will be used by the dentist to help determine appropriate and healthful dental treatment. If you have any changes to your medical status, please inform us. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits unless other wise stated. I also authorize the dentist to release all information necessary to secure the benefits due. I understand that I am financially responsible for all charges whether the insurance pays or not.

Signature____Date____________