Approximate Date of Last Dental Care_____ For What? _____

Date of last health care examination_____

For what?_____

Have you been hospitalized in the last 5 years?_____If so, for

what?_____

_____

Do you have or have you had any of the following. Please indicate with check mark (✔).

_____Any heart problems	_____Allergies to anesthesia	_____Hepatitis	_____Stroke
_____Mitral Valve Prolapse	_____Allergies to medicines	_____Herpes	_____Tonsillitis
_____High blood pressure	or drugs	_____Malignancies	_____Tuberculosis
_____Low blood pressure	_____Allergies to_____	_____Anemia	_____Arthritis
_____Circulatory problems	_____Asthma	_____Psychiatric care	_____Ulcer
_____Nervous problems	_____Diabetes	_____Rheumatic fever	_____Scarlet Fever
_____Radiation treatments	_____Artificial body parts		Other _____
_____HIV/AIDS	_____Smoker / How Long?_____		

Are you allergic to:	Yes	No
Penicillin	____	____
Local anesthetic	____	____
Medication or drugs	____	____
Women: Are you pregnant?	____	____

If allergic to medications or drugs, indicate which ones_____

Are you taking any medication_____If so, for what_____

Other Physical conditions_____

_____

Name of your Physician_____Phone_____

Are you receiving care now?_____If so, nature of care?_____

Are you now receiving other health care? ❑ Yes ❑ No

If so, nature of care?_____

Name of Doctor_____

Phone_____

I will inform the dentist of any medical history changes in the course of the patient's dental treatment.

I (We) hereby consent to the administration of anesthetic, x-rays, dental treatment, drugs and examinations that may be deemed necessary to the above mentioned patient.

As you know appointment times are valuable. Therefore, we ask that you notify our office in the event you need to cancel (24 Hrs. required). I understand there is a $50.00 "no-show" fee in the event I do not notify the office prior to my appointment time.
A fee of $15.00 will be charged for returned checks.

Signature X_____