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** DATE

____

Reviewed By Doctor