MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **Address:** _____

Date of Birth: _____ _____

Contact: Home (___)_____ **Email:** _____

Cell: (___)_____ **Business: (___)**_____

In case of emergency we should notify: _____
Name relationship phone

Family Doctor: _____
Name City phone date of last exam

1. Are you being treated for any medical condition at present or have you been treated within the past year? Y N

   Please explain _____

2. Are you taking any medications or non-prescription drugs? Y N

   Please specify _____

3. Do you have any known allergies? eg. Medications (Penicillin, codeine, latex) Y N

   Please specify _____

4. Have you ever had an adverse reaction to any medicine or injections? Y N

   Please specify _____

5. Have you ever been advised by your doctor to take antibiotics before dental treatment? Y N

6. Do you have or have you ever had any of the following? (Please circle appropriate condition)

Hepatitis, jaundice or liver disease	Y	N	Bleeding problem or bleeding disorder	Y	N
Prosthetic or artificial joint or valve	Y	N	Congenital heart disease, prosthetic cardiac valve	Y	N
Infective endocarditis, cardiac transplant	Y	N	High/ low blood pressure, stroke	Y	N
Chest pain, angina or heart attack	Y	N	Immune system: leukemia, AIDS, HIV infection	Y	N
Asthma, shortness of breath, lung disease	Y	N	Pacemaker	Y	N
Seizures/epilepsy	Y	N	Arthritis	Y	N
Stomach ulcers	Y	N	Diabetes (Type I or II)	Y	N
Cancer (Type, when)	Y	N	Kidney disease	Y	N
Thyroid disease	Y	N	Steroid therapy	Y	N
Tuberculosis	Y	N	Drug or alcohol disease	Y	N

7. Do you currently use any tobacco products _____ Y N

8. ***For women only:*** are you pregnant or breast feeding? _____ Y N

GENERAL RELEASE

I the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical – dental history**. Should there be any change in my health status in the future, I will advise the dental office**. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Patient/Guardian Signature **Print Name** **Date**

Insurance CO. **Policy Holder Name** **DOB:**

Employer: **Policy#** **ID#**

ESA APPROVAL

I hereby authorize the release of information contained in claims to be submitted electronically to my insuring company plans administrator.

Signature of patient or Parent/Guardian

Client#_____ Date_____

Checked by: _____ Date_____

PRIVACY APPROVAL

I hereby certify that I have been notified of the privacy policies of this office, who to contact regarding privacy concerns and how to request further information.

Signature of patient or Parent/Guardian

Client#_____ Date_____

Checked by: _____ Date_____