MEDICAL HISTORY

PATIENT:_____ Phone:_____ Cell: _____

Medical Physician_____ Date of Last Physical_____

YOUR ADDRESS _____**Cell** _____

Please list all Medications or Supplements You are Currently Taking and For What Conditions:

Medication/Supplement	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do You Have A Condition Requiring Pre-Medication (Antibiotic) Prior to Treatment? ☐**Yes** ☐**No**

If Yes, Antibiotic and Dosage: _____ For What Condition:_____

Allergies To: o Food_____ o Latex

o Medicine _____ o Anesthetic

(Women)Are you pregnant? oYes **o** No Nursing? **o**Yes **o** No Taking Birth Control? **o**Yes **o** No

Do You Have or Have You Had Any of the Following?

o AIDS
o Artificial Heart Valve
o Artificial Joints
o Asthma
o Back Problems
o Blood Disease
o Cancer_____
o Chemical Dependency
o Chemotherapy
o Circulatory Problems
o Cough, Persistent
o Diabetes
o Epilepsy
o Fainting
o Headaches/Migraines
o Heart Murmur
o Heart Problems
_____
o Hemophilia
o Hepatitis A, B, or C
Type ____Date Diag._____
o High **o**Low Blood Pressure
oHIV Positive
o Jaw Pain
o Kidney disease
o Liver Disease
o Lupus
o Mitral Valve Prolapse
o Pace Maker
o Radiation Treatment
o Respiratory Disease
o Sinus Trouble
o Stroke
o Thyroid Problems
o Tobacco Habit
o Tuberculosis
0 High/low Cholesterol
o Other _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*Signature of Patient (Parent if Minor)*_____*DATE*_____ ***2023***