1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name_____ Phone No. _____

   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES NO	Artificial Joints (hip, knee, etc.)	YES NO	Hepatitis B (serum)	YES NO
Heart Disease or Attack	YES NO	Kidney Trouble	YES NO	Venereal Disease	YES NO
Angina Pectoris	YES NO	Ulcers	YES NO	A.I.D.S.	YES NO
Congenital Heart Disease	YES NO	Diabetes	YES NO	H.I.V. Positive	YES NO
Heart Murmur	YES NO	Thyroid Problems	YES NO	Cold Sores/Fever Blisters	YES NO
High Blood Pressure	YES NO	Glaucoma	YES NO	Blood Transfusion	YES NO
Arteriosclerosis	YES NO	Cosmetic Surgery	YES NO	Hemophilia	YES NO
Mitral Valve Prolapse	YES NO	Emphysema	YES NO	Anemia	YES NO
Artificial Heart Valve	YES NO	Chronic Cough	YES NO	Sickle Cell Disease	YES NO
Heart Pacemaker	YES NO	Tuberculosis	YES NO	Bruise Easily	YES NO
Heart Surgery	YES NO	Asthma	YES NO	Liver Disease	YES NO
Rheumatic Fever	YES NO	Hay Fever	YES NO	Yellow Jaundice	YES NO
Arthritis	YES NO	Allergies or Hives	YES NO	Epilepsy or Seizures	YES NO
Rheumatism	YES NO	Sinus Trouble	YES NO	Fainting or Dizzy Spells	YES NO
Cortisone Medicine	YES NO	Radiation Therapy	YES NO	Nervousness	YES NO
Drug Addiction	YES NO	Chemotherapy	YES NO	Psychiatric Treatment	YES NO
Stroke	YES NO	Hepatitis A (infectious)	YES NO	Developmentally Disabled	YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month?_____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____