MEDICAL HISTORY

Physicians Name_____ _____ Phone number_____ Date of last visit_____
Your current medical health is:
Good_____ Fair_____ Poor_____

Are you currently under medical treatment?_____

Have you ever had any serious illness, operations, or been hospitalized in the past five years?_____

Are you currently taking any medications (Please list)
_____
Do you smoke?_____

Do you use alcohol, cocaine, or other drugs?_____

Do you wear contact lenses?_____

Do you have any allergies?
Latex_____
Local Anesthetics_____ Any other_____

Do you:
Snore____ Have Sleep Apnea____
Use a CPAP____

Women only: Are you
Pregnant? _____
Nursing? _____
Taking birth control pills? _____

Please check all that apply:

AIDS___
Anemia ___
Arthritis/Rheumatism___
Artificial Heart Valve___
Artificial Joints___
Asthma___
Back Problems___
Bleeding Abnormally___
Blood Disease___
Blood Disease___
Blood transfusion___
Cancer___
Chemical Dependency__
Chronic Fatigue Syndrome__
Circulatory Problems___
Congenital Heart Lesions___
Cortisone treatments___
Cough-Persistent or bloody___
Diabetes___
Emphysema ___
Epilepsy___
Fainting or dizziness___
Glaucoma___
Headaches___
Heart Murmur___
Heart Problem___
Hepatitis-Type___
Herpes___
High Blood Pressure___
HIV Positive___
Jaundice___
Jaw Pain___
Kidney Disease___
Latex Sensitivity___
Liver Disease___
Low blood pressure
Mitral Valve Prolapse
Nervous Problems____
Pacemaker___
Psychiatric Care___
Radiation Treatment___
Respiratory Disease___
Rheumatic Fever___
Scarlet Fever___
Shortness of breath___
Sinus Trouble___
Skin Rash___
Stroke___
Swelling of feet/ankles___
Swollen neck glands___
Thyroid Problems___
Tonsillitis___
Tuberculosis___
Tumor or growth on head/neck___
Ulcer___
Venereal Disease___

Please list any other conditions you may have had that are not listed above:_____

Our office is HIPPA, Complaint and is committed to meeting or exceeding the standards of the infect ion control mandated by OSHA, the CDC, and the ADA.

_____

I hereby authorize payment directly to Family and Cosmetic Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I hereby authorize release of any information, including the diagnosis and records of treatment or examination record, to my insurance.

Signature: _____ Date:_____