HEALTH HISTORY

Please Answer the following questions about the patient:

1. What is the purpose of the visit (Circle one or more)
   New Patient Examination / Cleaning / Tooth Problem / Consult / Others ______________________
2. Who referred the patient to us? ______________________
3. How long ago was it when the patient last visited a dentist? ______________________
4. Has the patient had regular dental examination (annually) in the past? ...... YES NO
5. Are you experiencing any pain or disomfort at this time? .... YES NO
6. Have you had a medical examination in the last year? .... YES NO
7. Do you feel very anxious about having dental treatment? .... YES NO
8. Have you been a patient in the hospital during the past two years? .... YES NO
9. Please state your physician's name ______________________ Phone # ______________
10. If you are using any medication now, please list ______________________
11. Please indicate any medication you are allergic to (including any sedative, pain killers, Penicillin or anesthetics)
    ____
12. Please indicate any other substance you are allergic to ______________________
13. Have you had or have at present any of the following? (Please Check ✓):

Allergies or Hives	Drug Addiction	Heart Disease or Attack	Cough
Anemia	Rheumatism	Fainting or Dizzy Spells	Angina Pectoris
Blood Transfusion	Scarlet Fever	Diabetes	Hemophilia
Bruise Easily	Chemotherapy	Any Lung Disease	Congenital Heart Lesions
Fever Blisters	High or Low Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice	Heart Pacemaker
Hepatitis A/B/C	Heart Failure	Emphysema	AIDS
Kidney trouble	Glaucoma	Ulcers	Pain in Jaw Joints
Sickle Cell Disease	Cosmetic Surgery	Rheumatic Fever	Sinus trouble
Stroke	Cortisone Medication	Nervousness	HIV +
Tuberculosis	Artificial Heart Valve	Thyroid Disease	Venerial Disease
Artificial Joints	Arthritis	Epilepsy or Seizures	X-ray or Cobalt Treatment
Cold Sores	Heart Surgery	Stomach Problems	Cancer
Chest Pains	Special Diet	Swelling	Tumor
Short of Breath	Frequent/Severe Headaches	Others ______________	

14. **Do you wish to speak privately about any medical condition? .... YES NO**
15. *FOR WOMEN ONLY* Are you pregnant? ....YES NO If yes, what month? ______________

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CONSENT and Financial Agreement

The undersigned hereby authorizes the Doctor, upon consultation and direct consent from Patient to take X-rays, study models, photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment (including the use of amalgam fillings), medication and therapy, that may be indicated in connection with the Patient further to my consultation and direct consent.

I understand that the responsibility of payment for Dental Services provided in this office for the Patient is mine, **due and payable at the time the services are rendered unless other financial arrangements have been made.** I also understand that I am responsible for any portion that the insurance/s may not cover as information on insurance coverage's, limits and any changes that may affect coverage's.

Signature of Patient, Parent or Guardian **x** ______________________ Date (D/M/Y) ______________