PATIENT NAME:______________________
Prefer to be Addressed by: (circle)
first name last name nickname
Date:______________________

HEALTH INFORMATION

PERSONAL PHYSICIAN:_______________________________________
NAME ADDRESS

YES	NO	
☐	☐	1. Have you been hospitalized within the past 2 years? For what?
☐	☐	2. Are you currently being treated by a physician? For what?
☐	☐	3. Are you currently taking any medicine, herbals, vitamins or over the counter drugs? What?
☐	☐	4. Are you allergic to any drugs? What?
☐	☐	5. Are you allergic to any metals or latex? What?
☐	☐	6. Do you bleed excessively upon injury?
☐	☐	7. Do you or have you ever used tobacco in any form?
☐	☐	8. Have you ever received counseling for use of alcohol or prescription drugs?
☐	☐	9. Are you pregnant, think you may be pregnant or nursing?
☐	☐	10. Do you need to be premedicated with antibiotics prior to your dental appointments? Why?

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

A. AIDS
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Nervous Breakdown or Psychiatric Therapy
P. Rheumatic Fever
Q. Sexually Transmitted Diseases
R. Stroke
S. Tuberculosis
T. Alzheimers/Parkinsons
U. Autoimmune Disorder
V. Joint Replacement
W. Bisphosphonate Therapy
X. Other condition that you would like to discuss privately with the doctor

Additional Information about above:
____
____

PERSON TO BE CONTACTED IN EMERGENCY

____
NAME ADDRESS PHONE#

AUTHORIZATION AND RELEASE

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 me or my child during the period of such dental care to third party payors and /or health practitioners.

Signature:X	Reviewed by:	Date:

Form V4.1