Patient Name _____ _____

Medical History

Physician's Name: _____ Date of Last Physical: _____

Have you had any serious Illnesses or operations? Yes / No

If yes please describe: _____

(Women) Are you Pregnant? Yes/ No # of Weeks: _____

Have you ever been treated for: (please circle any that apply to you)

Alcoholism	Cold Sores	HIV Positive	Rheumatic Fever
Anemia	Diabetes	Jaw Pain	Scarlet Fever
Arthritis, Rheumatism	Drug Addiction	Kidney Disease	Sinus Problems
Artificial Heart Valves	Emphysema	Liver Disease	Steroid Medications
Asthma	Epilepsy	Low Blood Pressure	Stroke
Back Problems	Fainting	Mirtal Valve Prolapse	Thyroid Problems
Blood Disease	Glaucoma	Pacemaker	Tuberculosis
Blood Transfusions	Headaches	Prosthetic Joints	Tobacco Habit
Cancer	Heart Murmur	Psychiatric Care	Ulcer
Chemical Dependency	Hepatitis	Radiation Treatment	Venereal Disease
Chemotherapy	High Blood Pressure	Rashes	

List medications you are currently Taking:

_____
_____
_____

List Any Allergies:

_____
_____
_____

Would you like to speak to the Doctor privately about any problem? Yes / No

Authorization and Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits direct to the dentist or dental group, otherwise payable to me. I understand that I am financially responsible for all charges whether or not they are paid by insurance, and that I am responsible for payment in full on all accounts. Our financial policy is to receive payment in full by the time treatment is completed. Interest, at the annual rate of 1.5 % per month will be added to any balance over 60 days starting from the date the charges were made. Any account over 60 days delinquent will be turned over to a collection agency. If this account is assigned to an outside agency for collections, I/WE agree to pay all attorney fee, court costs, and collection charge of 40% which will be added to the outstanding balance of my account.

Patient or Parent / Guardian Signature _____ Date _____