Have you been under the care of a physician during the past 2 years? ....YES NO
When was your last complete physical? ____________________
Are you taking any medications now? (if so, please list below)..YES NO

LIST MEDICATIONS HERE

Are you allergic to: Penicillin.........YES NO   Pain killers.........YES NO   Local anesthetic.........YES NO

Have you ever been treated for:

Heart disease or murmur.............YES NO
High blood pressure....................YES NO
Stroke..YES NO
Rheumatic Fever..........................YES NO
Heart valve replacement ....YES NO
Artificial hip/knee joints ....YES NO
Allergies......................................YES NO
Fainting/Dizziness ....YES NO

Jaundice...................................YES NO
Ulcers ....YES NO
Thyroid problems ....YES NO
Tuberculosis ....YES NO
Arthritis....................................YES NO
Glaucoma ....YES NO
Radiation/Chemotherapy ....YES NO
Epilepsy/Seizures ....YES NO

Hepatitis A................................YES NO
Hepatitis (serum).......................YES NO
Venereal disease ....YES NO
H.I.V. Positive...........................YES NO
Cold sores/Fever blisters ....YES NO
Blood Transfusions...................YES NO
Anemia ....YES NO
Drug/Substance Abuse ....YES NO
Psychiatric treatment ....YES NO

Do you smoke?.............YES NO   If so, how much? __________   Do you use smokeless tobacco? ....YES NO
Do you have any diseases, conditions, or problems not listed above? ____________________

For women only:

Are you pregnant?.............YES NO   Are you nursing?..................YES NO
Are you using birth control pills/patches? ....YES NO

DENTAL HISTORY

When was your last dental visit?__________   Name of previous dentist__________
Have you had any serious problems associated with previous dental treatment? ....YES NO
How often do you brush your teeth?__________   What type of brush do you use?...........Soft Med Stiff
How often do you floss? __________   Do your gums bleed?...YES NO
Do you clench or grind your teeth? ....YES NO   Do your jaws ever feel tired or ache?......................YES NO
Do you feel you will eventually lose your teeth ....YES NO

CONSENT:

I have answered all questions truthfully and to the best of my knowledge. The undersigned hereby authorizes Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with patient's dental needs, and further authorize and consent that Doctor may choose and employ such assistance as deemed fit. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine. I further understand that a 1.75% monthly finance charge may be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note.

__________ (Patient's name)   __________ (Signature of responsible party)   __________ (Date)

Health History Update:

Any changes to the above information? .....YES NO   If yes, please explain__________

(Date)   (Patient's initials)

Any changes to the above information? .....YES NO   If yes, please explain__________

(Date)   (Patient's initials)

Any changes to the above information? .....YES NO   If yes, please explain__________

(Date)   (Patient's initials)

HEALTH HISTORY