HEALTH HISTORY FORM

1. Are you having pain or discomfort at this time? ..... YES☐ NO☐
2. Do you feel very nervous about having dental treatment? ..... YES☐ NO☐
3. Have you ever had a bad experience in a dental office? ..... YES☐ NO☐
4. Have you been a patient in the hospital during the past two years? ..... YES☐ NO☐
5. Have you been under the care of a medical doctor during the past two years? ..... YES☐ NO☐
   Your Physician's Name: _____
   Address: _____ Phone Number: _____
6. Are you now taking any medication, drugs, or pills? ..... YES☐ NO☐
   If yes, please list: _____
7. Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance? YES☐ NO☐

   If yes, please list: _____
8. Indicate which of the following you have had, or have at present. Check "yes" or "no" next to each.

Heart Failure	YES☐ NO☐	Tuberculosis	YES☐ NO☐	Hepatitis A (infectious)	YES☐ NO☐
Heart Disease	YES☐ NO☐	Asthma	YES☐ NO☐	Hepatitis B (serum).....	YES☐ NO☐
Angina Pectoris	YES☐ NO☐	Diabetes	YES☐ NO☐	Hepatitis C.....	YES☐ NO☐
High Blood Pressure	YES☐ NO☐	Thyroid Disease	YES☐ NO☐	Liver Disease	YES☐ NO☐
Heart Murmur	YES☐ NO☐	Cancer	YES☐ NO☐	Yellow Jaundice	YES☐ NO☐
Rheumatic Fever	YES☐ NO☐	Arthritis	YES☐ NO☐	Blood Transfusion	YES☐ NO☐
Congenital Heart Lesions	YES☐ NO☐	A.I.D.S.	YES☐ NO☐	IV Drug Use	YES☐ NO☐
Artificial Heart Valve	YES☐ NO☐	Organ Transplant	YES☐ NO☐	Hemophilia	YES☐ NO☐
Heart Pacemaker	YES☐ NO☐	Anemia	YES☐ NO☐	Bruise Easily	YES☐ NO☐
Heart Surgery	YES☐ NO☐	Stroke	YES☐ NO☐	Cold Sores	YES☐ NO☐
Kidney Trouble	YES☐ NO☐	Epilepsy or Seizures	YES☐ NO☐	Fainting or Dizzy Spells	YES☐ NO☐
Dialysis Patient	YES☐ NO☐				

9. Do you have any disease, condition, or problem not listed? ..... YES☐ NO☐
   If yes, please list: _____

WOMEN ONLY: Are you pregnant? YES☐ NO☐ If yes, what month? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully, and to the best of my knowledge.

Patient Signature _____ Date _____/_____/_____

CONSENT:

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic acts deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that the Doctor choose and employ such assistance as deemed fit. I also understand the 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 dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made in writing. I further understand that a 1 ½ % finance charge (18% annually) will be added to any balance over 60 days from when treatment was received. In event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date_____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____