

First Name _____ Middle Name _____ Last Name _____

Medical Physician _____ Phone () _____

Physician Address _____ Kaiser Number _____

Patient Social Security Number _____ Patient Email Address _____

Medical History

Birth Date ____ / ____ / ____

Do you consider yourself in good health? _____ If no, please explain _____

Do you have an existing illness? _____ If yes, please explain _____

Have you been hospitalized in the last two years? _____ If yes, please explain _____

Do you smoke or use tobacco? Yes No If yes, have you attempted to quit? _____

Do you have allergies to any of the following?

- | | | | |
|----------------------------------|---------------------------------------|---|--------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | Other: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Dental Anesthetics | _____ |

Please check either Yes or No for each of the following as it applies to your health history:

- | | | | |
|---|--|---|---|
| Y/N | Y/N | Y/N | Y/N |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies/Hives | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Anemia/Blood Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells/Seizure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stoke/TIA |
| <input type="checkbox"/> Artificial Bones | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Taken Phen-Fen |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Prosthetic/Implant Placement | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold Sores/Herpes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Yellow Jaundice |

Do you wear contact lenses? Yes No

List medications (including over the counter medications) you are taking: _____

Women: Are you taking birth control pills? Yes No Are you Pregnant? Yes No

Remarks or Note Any Other Serious Illness NOT Listed Above: _____

I understand that the information given here is, to the best of my knowledge, correct. I also understand that this information will be held in STRICT CONFIDENCE; and it is my responsibility to inform this office of any changes in my medical status. With my informed consent, I authorize the dental staff to perform any necessary dental service(s) indicated during diagnosis and treatment. I understand that I am financially responsible for any balance due, regardless of insurance coverage. If I have insurance, I hereby authorize my insurance benefits to be paid directly to the dentist. I authorize the use of photographs of me taken for the purpose of patient education during my diagnosis or treatment. I also authorize the dentist to release any information required for payment to be made. I am fully aware there may be a charge to provide and transfer any dental records to another dental office, per my written request. Finally, I understand that after 60 days, a service charge of 18% annually will be charged monthly on any unpaid balance.

Signature of Patient _____ Date _____
(Or Guardian if under 18 years of age)

(Doctor's Signature) _____ Date _____