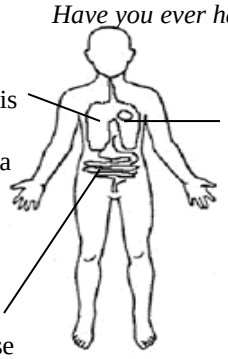
PATIENT MEDICAL & DENTAL HISTORY

Patient name_____ Phone (_____) _____-_____

Circle (yes) or (no)		PATIENT MEDICAL HISTORY
yes	*no*	Are you under any medical treatment now?_____
yes	*no*	Have you had any **major medical operations**? What?_____
yes	*no*	Have you ever had a serious injury involving the head or jaws?_____
yes	*no*	Have you ever had any **adverse reactions** to medication? Which?_____
yes	*no*	*Have you ever had any **allergic reactions** to medication? (penicillin? aspirin?)*_____

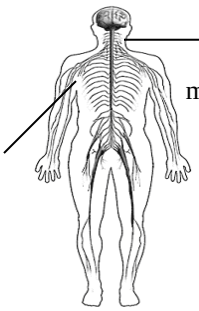
Circle all that apply



Tuberculosis
Asthma
Emphysema
Pneumonia
Hepatitis
Liver disease

heart attack
heart ailment
rheumatic fever
Rheumatic heart disease
Pacemaker
Heart murmur
Artificial heart valve
irregular/ rapid heart beat
congestive heart disease

low blood pressure
high blood pressure
hemophilia
HIV/AIDS
blood disease
stroke
kidney disease



Epilepsy
convulsions
mental disorder
schizophrenia
depression
diabetes

yes *no* Do you have any conditions or diseases that are not mentioned above? Please name them_____

CURRENT MEDICATIONS	TO CONTROL

yes *no* Do you have any reason to suspect that you are not in good health?
yes *no* Are you pregnant?
yes *no* Do you smoke, drink, or use recreational drugs?
yes *no* Have you ever had or do you have cancer? Which one(s)?_____
yes *no* Have you ever had chemotherapy or been treated with radiation?
yes *no* Does you physician recommend ***antibiotic prophylaxis*** for dental procedures?
yes *no* Have you ever received any donor organs or major joint replacements (knee, hip, ect,.)?

PATIENT DENTAL HISTORY

yes *no* Do you have any specific problems or concerns?
yes *no* Do you have any pain in or near your ears?
yes *no* Do you have any growths or sore spots in your mouth? Where?_____
yes *no* Have you ever had any adverse reactions to local anesthetic (novacaine)?
yes *no* Do you grind or clench your teeth?
yes *no* Have you ever had a difficult tooth extraction or prolonged bleeding following a tooth extraction?
yes *no* Do your gums bleed?
yes *no* Do you chew on one side of your mouth? Why?_____
yes *no* Have you ever had a bad dental experience? Explain_____

Why did you leave your prior dentist?_____
When was your last full mouth series of x-rays taken? _____/_____/_____

I certify that the answers given are correct to the best of my knowledge and will inform Dr. Taras of any changes.
Preferred method of payment. ____Cash ____Check _____ Visa ____ MasterCard _____ Discover

I understand that **payment is due at the time of treatment** and that the charges incurred by me and my dependants are my responsibility (whether my dental insurance pays as I expect or not). I also understand that a 1.5% monthly service charge may be added to any balance that is 30 days past due, from the time treatment is received.

PATIENT SIGNATURE_____ DATE_____/_____/_____

DENTIST SIGNATURE_____ DATE_____/_____/_____