LAST NAME ______________________________ **FIRST NAME** ______________________________

1.	**NAME OF PHYSICIANS**	**ADDRESS**	**SPECIALTY**	**PHONE**
	____________________	____________________	______________	____________
	____________________	____________________	______________	____________
	____________________	____________________	______________	____________

2. Are you currently under a doctor's care now? (Reason:___________________________) Yes No
3. Have you been hospitalized within the past two years? (Reason:_____________________) Yes No
4. How long has it been since your last physical examination? _______________________
5. Please list all medications you are currently taking:

MEDICATION	**REASON**
____________________	______________________________
____________________	______________________________
____________________	______________________________

6. Are you allergic or ever had an adverse reaction to any of the following:

YES	NO	Penicillin	YES	NO	Codeine	YES	NO	Tylenol
YES	NO	Erythromycin	YES	NO	Fluoride	YES	NO	Aspirin
YES	NO	Novocaine	YES	NO	Epinephrine	YES	NO	Sulfa
YES	NO	Latex	YES	NO	Other _______________			

7. Are you subject to prolonged bleeding? Yes No
8. Have you been tested or diagnosed as having or carrying the Aids Virus? Yes No
9. Have you had a blood transfusion in the past five years? Yes No
10. Have you had a blood transfusion prior to 1985? Yes No
11. Are you subject to fainting spells? Yes No
12. WOMEN: Are you pregnant? Due Date:____________ Yes No

13. **Do you have – or – have you ever had any of the following** (**Please Circle**):

YES	NO	Mitral Valve Prolapse	YES	NO	Blood Disease	YES	NO	Thyroid Disease
YES	NO	Heart Murmur	YES	NO	Anemia	YES	NO	Scarlet Fever
YES	NO	Artificial Heart Valve	YES	NO	Sickle Cell Anemia	YES	NO	Epilepsy
YES	NO	Congenital Heart Lesions	YES	NO	Liver Disease	YES	NO	Arthritis
YES	NO	Heart Pacemaker	YES	NO	Jaundice	YES	NO	Cancer
YES	NO	Heart Surgery	YES	NO	Hepatitis A B C	YES	NO	Kaposi's Sarcoma
YES	NO	Rheumatic Fever	YES	NO	Hypoglycemia	YES	NO	Chemotherapy
YES	NO	Joint Replacement	YES	NO	Diabetes	YES	NO	X-ray Treatments
YES	NO	Chest Pains	YES	NO	Glaucoma	YES	NO	Venereal Disease
YES	NO	Shortness Of Breath	YES	NO	Tuberculosis	YES	NO	Nervous Disorder
YES	NO	Swelling Of Feet / Ankles	YES	NO	Asthma	YES	NO	Emphysema
YES	NO	Stroke: When:_________	YES	NO	Hay Fever	YES	NO	Psychiatric Care
YES	NO	High Blood Pressure	YES	NO	Sinus Problems	YES	NO	Drug Dependence
YES	NO	Low Blood Pressure	YES	NO	Cold sores	YES	NO	Fever Blisters
YES	NO	Circulatory Problems	YES	NO	Kidney Disease	YES	NO	Hearing Problem
YES	NO	Angina	YES	NO	Hemophilia	YES	NO	Organ Transplant

The undersigned hereby authorizes the doctor to perform any and all forms of dental treatment, medications and therapy that may be indicated. I grant the right for the release of health information and information about my medical and dental health and treatment to third party payers and/or other health practitioners. The above information is correct to the best of my knowledge. *Please type your name in the signature field to enact your signature.

Patient (Parent) Signature____ **Date**________________

____ **Date**________________

HEALTH HISTORY