ALL SMILE DENTAL

MEDICAL HISTORY

1. Are you under any medical treatment now? . . . . . Yes or No

Physician: _____ Office Phone: _____ Date of last exam: _____

2. Have you ever been hospitalized for any surgical operation or serious illness within last 5 yrs? . . Yes or No
   If yes please explain: ……
3. Are you taking any medication (s) including non-prescription medicine? . . . . . Yes or No
   If yes, please list you medication(s):……
4. Do you use tobacco? . . . . . .Yes or No
5. Have you ever taken phen phen(weight reducing med)or Bisphosphonates(Bone med)?. . . . . ..Yes or No
6. Do you use controlled substances? . . . . . .Yes or No
7. Are you wearing contact lenses? . . . . . Yes or No
8. Do you have or had any of the following: (Please Circle yes or no)

High blood Pressure	Y N	Low Blood Pressure	Y N	Chest Pain	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Heart Disease	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Heart Trouble	Y N	Angina	Y N	Mitral Valve Prolapse	Y N
Fainting/Seizures	Y N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anemia	Y N	Radiation Therapy	Y N
Bruise easily	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy/Convulsions	Y N	Cancer	Y N	Recent Weight Lost	Y N
Leukemia/blood disrder	Y N	Arthritis	Y N	Respiratory problems	Y N
Diabetes	Y N	Joint replacement/implant	Y N	Swollen Ankles	Y N
Kidney Disease	Y N	Hepatitis / Jaundice	Y N	Liver Disease	Y N
AIDS or HIV infection	Y N	Stomach troubles/ulcer	Y N	Hay Fever/Allergies	Y N
Thyroid problem	Y N	Sexually transmitted Disease	Y N	Other: _____	

9. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	Y N	Aspirin	Y N	Sedatives	Y N
Penicillin or any other antibiotics	Y N	Any metals	Y N	Latex Rubber /Powder	Y N
Sulfa Drugs	Y N	Iodine	Y N	Other: _____	Y N

10. **Women ONLY:**

a) Are you pregnant or think you May be pregnant? Y N

b) Are you Nursing? Y N

c) Are you taking any oral Contraceptives? Y N

Authorization and Release

I certify that I have read, understand & accurately answered the above information to the best of my knowledge as providing incorrect information can be dangerous to my health. I authorize the dentist to release my information rendered to my child or me to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I give consent for e-mail/ text communication regarding appointment & treatment. As this is not always secure method, our office don't communicate any personal health info. I consent to the dental x-rays, diagnostic procedures and treatment by the dentist necessary for proper dental care.

_____ Signature of Patient / Parent / Guardian and Date

_____ Dentist's Signature and Date

FOR FUTURE VISITS/APPOINTMENTS ONLY- RECALL REVIEW UPDATE & COMMENTS:

Any change(s) in health history or Medical condition? *If Yes, Please explain:*

	Patient's signature	Date	Dentist Signature
❑ *Yes* ❑ *No*			
❑ *Yes* ❑ *No*			
❑ *Yes* ❑ *No*			