Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Have you been vaccinated for COVID-19? If YES, which vaccine and when?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Anemia
☐ Angina	☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint
☐ Asthma	☐ Blood Disease	☐ Blood Transfusion	☐ Breathing Problems
☐ Bruise Easily	☐ Cancer	☐ Chemotherapy	☐ Chest Pains
☐ Cold Sores/Fever Blisters	☐ Congenital Heart Disorder	☐ Convulsions	☐ Cortisone Medicine
☐ COVID-19	☐ Diabetes	☐ Drug Addiction	☐ Easily Winded
☐ Emphysema	☐ Epilepsy or Seizures	☐ Excessive Bleeding	☐ Excessive Thirst
☐ Fainting Spells/Dizziness	☐ Frequent Cough	☐ Frequent Diarrhea	☐ Frequent Headaches
☐ Genital Herpes	☐ Glaucoma	☐ Hay Fever	☐ Heart Attack/Failure
☐ Heart Murmur	☐ Heart Pacemaker	☐ Heart Trouble/Disease	☐ Hemophilia
☐ Hepatitis A	☐ Hepatitis B or C	☐ Herpes	☐ High Blood Pressure
☐ High Cholesterol	☐ Hives or Rash	☐ Hypoglycemia	☐ Irregular Heartbeat
☐ Kidney Problems	☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure
☐ Lung disease	☐ Mitral Valve Prolapse	☐ Osteoporosis/Osteopenia	☐ Pain in Jaw Joints
☐ Parathyroid Disease	☐ Psychiatric Care	☐ Radiation Treatments	☐ Recent Weight Loss
☐ Renal Dialysis	☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever
☐ Shingles	☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Spina Bifida
☐ Stomach/Intestinal Disease	☐ Stroke	☐ Swelling of Limbs	☐ Thyroid Disease
☐ Tonsillitis	☐ Tuberculosis	☐ Tumors or Growths	☐ Ulcers
☐ Venereal Disease	☐ Yellow Jaundice		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

OUR CREDIT POLICY:
We are here to help you as best as we can. We will process your insurance for you as a courtesy. If your account is over 60 days, a service fee of 1.5% per month, which is an annual percentage rate of 18%, will be added to your account. By signing below, you understand that you are responsible for this bill, even though you may have dental insurance. If you let your account become delinquent, services charges and any previous discounts given will be added to your balance. You will be responsible for ALL COLLECTION COSTS, including attorney's fees. You authorize any past due account balance to be applied to the credit card on file.

I WISH TO ESTABLISH CREDIT WITH (circle1) MASTERCARD VISA DISCOVER

My Card # is:_____ the expiration date is:_____ CVV:_____

My drivers license # is:_____. I agree that if my account becomes delinquent (90 days), unless other arrangements have been made in writing, the balance on the account will be applied to the credit card on file.

I WISH TO PAY WITH CASH OR CHECK AT EACH APPOINTMENT: (initial) _____

Signature of Patient, Parent or Guardian:

X Date:_____