RAN

Medical History Form

Medical History

Yes	No		
☐	☐	1.	Are you currently under the care of a physician?
☐	☐	2.	Are you currently taking any medication?
☐	☐	3.	Are you allergic to any medication?
☐	☐	4.	Have you ever had a rheumatic fever, heart surgery, a heart murmur, or a joint replacement?
☐	☐	5.	Have you ever had cancer, radiation treatment, or chemotherapy?
☐	☐	6.	Have you ever had a reaction to local anesthetic (Novocain) or general anesthetic?
☐	☐	7.	Have you ever had any injury to you face or jaw?
☐	☐	8.	Do you have high or low blood pressure? ☐ High ☐ Low
☐	☐	9.	Have you had a heart attack, chest pains, or a pacemaker?
☐	☐	10.	Have you had shortness of breath, asthma, tuberculosis, or any other breathing problems?
☐	☐	11.	Do you have intestinal or stomach problems?
☐	☐	12.	Have you had kidney or bladder trouble?
☐	☐	13.	Have you had hepatitis, jaundice, or liver disease?
☐	☐	14.	Do you or anyone in your family have diabetes? Who? _____
☐	☐	15.	Have you had a stroke, seizure, or convulsive disorder?
☐	☐	16.	Do you have arthritis or rheumatism?
☐	☐	17.	Do you have a tendency to bleed longer than normal?
☐	☐	18.	Do you have a bleeding disorder such as anemia or leukemia?
☐	☐	19.	Have you been hospitalized in the last 5 years?
☐	☐	20.	Have you tested positive for HIV or Aids virus?
☐	☐	21.	Are you or have you been treated for chemical dependency?
☐	☐	22.	Do you use tobacco?
		23.	Have you taken any of the following medications in the last 6 months?
☐	☐		▯ Cortisone or other steroids
☐	☐		▯ Anticoagulants or blood thinner
☐	☐		▯ Tranquilizers or antidepressants
☐	☐		▯ Aspirin in large doses or frequently
☐	☐	24.	Do you have any other health problems? If so, please list: _____
☐	☐	25.	Are you pregnant?
☐	☐	26.	Are you taking birth control pills?

Doctor's comments _____

RAN

Medical History Form

Dental History

1. What is the reason for coming to our dental office today?

   _____

2. How long has it been since you have seen a dentist?

   _____

3. Have you ever had any complications during or following dental treatment? ☐ Yes ☐ No
   If yes, please explain. _____

4. Do you have pain, soreness, or clicking in your jaw joints jaw muscles? ☐ Yes ☐ No
   If yes, please explain. _____

5. Are there any other dental concerns or problems you have? ☐ Yes ☐ No
   If yes, please explain. _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medications change, I will inform this office at the next appointment without fail.

Payment Information

Payment is due on the day of treatment.

There are no payment plans for any services rendered under $100.00. For procedures that require more than one visit, half the fee is due the day the procedure is started, and the other half is due by the time the procedure is completed. If this presents a problem, you must speak with the receptionist at this time about any issues you have. Finance charges are 18% per year and accrue on all accounts over 30 days old. Accounts 90 days past due are turned over to a collection agency. We accept MasterCard, Visa, Discover, cash, and personal checks.

Patient (parent or guardian) signature _____ Date _____

Doctor's signature _____ Date _____