1. Are you having pain or discomfort at this time? Yes No
2. Have you been a patient in the hospital in the last two years? Yes No
3. Have you been under the care of a physician in the last two years? Yes No

   Physician's Name _____

   Address _____ Phone Number _____
4. Have you taken any medications or drugs in the last two years? Yes No
5. Are you now taking any medications, drugs, or pills? Yes No

   If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? Yes No

   If yes. please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure Yes No	Stroke Yes No	Hepatitis A (Infectious) Yes No
Heart Disease or Attack Yes No	Artificial Joints(hip, knee, etc) Yes No	Hepatitis B (Serum) Yes No
Angina Pectoris Yes No	Kidney Trouble Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Ulcers Yes No	A.I.D.S. Yes No
Heart Murmur Yes No	Diabetes Yes No	H.I.V. Positive Yes No
High Blood Pressure Yes No	Thyroid Problems Yes No	Cold Sores / Fever Blisters Yes No
Arteriosclerosis Yes No	Glaucoma Yes No	Blood Transfusion Yes No
Mitral Valve Prolapse Yes No	Cosmetic Surgery Yes No	Hemophilia Yes No
Artificial Heart Valve Yes No	Emphysema Yes No	Anemia Yes No
Heart Pacemaker Yes No	Chronic Cough Yes No	Sickle Cell Anemia Yes No
Heart Surgery Yes No	Tuberculosis Yes No	Bruise Easily Yes No
Rheumatic Fever Yes No	Asthma Yes No	Liver Disease Yes No
Arthritis Yes No	Hay Fever Yes No	Yellow Jaundice Yes No
Rheumatism Yes No	Allergies or Hives Yes No	Epilepsy or Seizures Yes No
Pain in Jaw Joints Yes No	Sinus Trouble Yes No	Fainting or Dizzy Spells Yes No
Cortisone Medicine Yes No	Radiation Therapy Yes No	Nervousness Yes No
Drug Addiction Yes No	Chemotherapy Yes No	Psychiatric Treatment Yes No

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Yes No
9. Do your ankles swell during the day? Yes No
10. Do you use more than two pillows to sleep? Yes No
11. Have you lost or gained more than ten pounds in the last year? Yes No
12. Do you ever wake up from sleep feeling short of breath? Yes No
13. Are you on a special diet? Yes No
14. Has your medical doctor ever said you have cancer or a tumor? Yes No
15. Do you have any problem, disease, or condition not listed? Yes No

    If yes, please list: _____

For Women Only:

Are you pregnant? No / Yes, What month? _____ Are you nursing? No / Yes Are you now taking birth control pills? No / Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies certain risks. I understand the responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered, unless financial arrangements are made. I further understand that a 1.5% finance charge (18% annually) will be added to my balance over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and attorney's fees as may be required to effect collection of this matter

Patient Signature _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____