Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No
   If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)..	Yes	No	Ulcers.....	Yes	No	Hepatitis A B C (circle)...	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S./H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
High/Low Blood Pressure.....	Yes	No	Contact lenses.....	Yes	No	Blood Transfusion.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Artificial Heart Valve/Pacemaker..	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Asthma.....	Yes	No	Liver Disease/Yellow Jaundice..	Yes	No
Cortisone Medicine.....	Yes	No	Hay Fever/Allergy/Hives.....	Yes	No	Neurological Disorders.....	Yes	No
Swollen Ankles.....	Yes	No	Latex Sensitivity.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Artificial Joints(hip,knee, etc.)....	Yes	No	Chemotherapy.....	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No			

8. Are you aware of having an allergic (or adverse) reaction to any substance or medication? (Please List) ..... Yes No
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
    If yes, please list: _____
11. Women: Are you pregnant or think you could be pregnant? Yes _____ Months No Nursing? Yes No
12. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the HIPAA of 1996, I have certain rights to privacy regarding my protected health information. This information can and will be used to A. Conduct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly. B. Obtain payment from third-party payers. C. Conduct normal healthcare operations such as quality assessments and physician certification. Complete statement provided upon request.