Do you have any allergies?

Latex\_\_\_\_\_

Local Anesthetics\_\_\_\_\_ Any other\_\_\_\_\_\_\_\_\_\_\_

Do you:

Snore\_\_\_\_ Have Sleep Apnea\_\_\_\_

Use a CPAP\_\_\_\_

**Women only**: Are you

Pregnant? \_\_\_\_\_

Nursing? \_\_\_\_\_

Taking birth control pills? \_\_\_\_\_\_

MEDICAL HISTORY

Our office is HIPPA, Complaint and is committed to meeting or exceeding the standards of the infect ion control mandated by OSHA, the CDC, and the ADA. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment directly to Family and Cosmetic Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I hereby authorize release of any information, including the diagnosis and records of treatment or examination record, to my insurance.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

AIDS\_\_\_ Emphysema \_\_\_ Pacemaker\_\_\_

Anemia \_\_\_ Epilepsy\_\_\_ Psychiatric Care\_\_\_

Arthritis/Rheumatism\_\_\_ Fainting or dizziness\_\_\_ Radiation Treatment\_\_\_

Artificial Heart Valve\_\_\_ Glaucoma\_\_\_ Respiratory Disease\_\_\_

Artificial Joints\_\_\_ Headaches\_\_\_ Rheumatic Fever\_\_\_

Asthma\_\_\_ Heart Murmur\_\_\_ Scarlet Fever\_\_\_

Back Problems\_\_\_ Heart Problem\_\_\_ Shortness of breath\_\_\_

Bleeding Abnormally\_\_\_ Hepatitis-Type\_\_\_ Sinus Trouble\_\_\_

Blood Disease\_\_\_ Herpes\_\_\_ Skin Rash\_\_\_

Blood Disease\_\_\_ High Blood Pressure\_\_\_ Stroke\_\_\_

Blood transfusion\_\_\_ HIV Positive\_\_\_ Swelling of feet/ankles\_\_\_

Cancer\_\_\_ Jaundice\_\_\_ Swollen neck glands\_\_\_

Chemical Dependency\_\_ Jaw Pain\_\_\_ Thyroid Problems\_\_\_

Chronic Fatigue Syndrome\_\_ Kidney Disease\_\_\_ Tonsillitis\_\_\_

Circulatory Problems\_\_\_ Latex Sensitivity\_\_\_ Tuberculosis\_\_\_

Congenital Heart Lesions\_\_\_ Liver Disease\_\_\_ Tumor or growth on head/neck\_\_\_

Cortisone treatments\_\_\_ Low blood pressure Ulcer\_\_\_

Cough-Persistent or bloody\_\_\_ Mitral Valve Prolapse Venereal Disease\_\_\_

Diabetes\_\_\_ Nervous Problems\_\_\_\_

Please list any other conditions you may have had that are not listed above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under medical treatment?\_\_\_\_\_\_\_\_

Have you ever had any serious illness, operations, or been hospitalized in the past five years?\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications (Please list)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke?\_\_\_\_\_\_

Do you use alcohol, cocaine, or other drugs?\_\_\_\_\_

Do you wear contact lenses?\_\_\_\_\_\_\_\_

Physicians Name\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit\_\_\_\_\_\_\_\_\_\_

Your current medical health is:

Good\_\_\_\_\_\_\_ Fair\_\_\_\_\_\_ Poor\_\_\_\_\_\_