# Health History

*Please check all that apply:*

**Do you need premedication?** _____ Why? _____

**Have you ever had**: Heart murmur _____, an artificial heart valve _____, artificial joint____, Rheumatic fever _____, mitral valve prolapse _____, Orthopedic pins_____, pacemaker___, other heart problems _____

**Do you have:** AIDS ____, HIV ____, Hepatitis ____ (if yes what type? _____) Herpes _____, a venereal disease _____

**Do you have:** a blood disease _____, hemophilia _____, anemia _____, excessive bleeding with extractions or surgery ____

**Do you have:** diabetes ___, asthma ___, emphysema ____, epilepsy ____, Thyroid problem ___ liver disease ____, shortness of breath ____, tuberculosis ____, high blood pressure ____

**Have you ever had:** cancer ____, chemotherapy _____, radiation ____

**Do you have :** a tobacco habit ____, a chemical dependency _____

**Have you ever** taken medicine for osteoporosis: _____ Drug name _____

**Are you** allergic to Latex? _____

**Are you allergic to:** Acrylic _____, aspirin _____, codeine _____, Iodine ___, Local anesthesia ____, metals ____, Penicillin ____, Sulfa ____, other _____

**Question for women:** Are you pregnant? _____ If so, due date: _____

**Please list all medications you are currently taking:** _____

_____

**Pharmacy name, address & phone** _____

**Authorization & Release:**
**I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.**

**Signature of Patient (or parent if minor)**_____

**Date**_____

**Reason for today's visit?** _____

**Who should we thank for referring you?** _____