Print Patient Name: Date of Birth:

MEDICAL HISTORY (Please check any of the following conditions you may have.)

- Heart Disease
- Heart Attack
- Prolapsed Mitral Valve
- Rheumatic Fever
- Rheumatic Heart Disease
- Heart Surgery DATE_____
- Prosthetic Heart Valve
- Angina
- Congenital Heart Defect
- Pacemaker
- Other Heart Issues (explain)
- Stroke
- High Blood Pressure
- Emphysema
- Asthma/Hay fever
- Sinus Trouble/Allergies
- Tuberculosis
- Hepatitis
- Diabetes
- Steroid Therapy
- Epilepsy
- Fainting Spells/Seizures
- Anticoagulants (Blood Thinners)
- Auto Immune Deficiency Syndrome
- Chronic Pain (explain)
- Bleeding Problems
- Blood Transfusions
- Anemia (low blood)
- Leukemia
- Liver Disease
- TMJ (Jaw Joint Problems)
- Cancer/Tumor
- Stomach Ulcers
- Drug Dependency
- HIV Positive
- Joint Replacement Date_____
- Thyroid Disorder
- Surgery in the past year (Explain Reason/Date)

Are you under the care of a physician?
☐ YES ☐ NO If yes, please explain.

Do you want Nitrous Oxide? YES NO

Additional charge, not usually covered by Insurance $

PHYSICIAN AND PHARMACY INFORMATION

Physician Name:

Physician Phone: ( )

Preferred Pharmacy: ℞

Pharmacy Phone: ( )

MEDICATIONS

Are you currently taking any medications? Yes No
Please list any current medications & supplements (use a separate sheet if necessary)

ALLERGIES

NO KNOWN ALLERGIES

I am allergic or have had a reaction to the following:

- Latex
- Penicllin
- Codeine
- Asprin
- Sulfa Drugs
- Other, Please List

FOR WOMEN ONLY

Are you or could you be pregnant? YES NO
Are you nursing? YES NO
Are you taking birth control pills? YES NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

Signature of PATIENT or GUARDIAN DATE