Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

☐ Are you under medical treatment now?
☐ Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____
_____
_____

☐ Are you taking any medication(s) including non-prescription medicine?
If yes, what medication(s) are you taking? _____
_____
_____

☐ Have you ever taken Fen-Pehn/Reduc?
☐ Do you use tobacco?
☐ Do you use controlled substances?
☐ Are you wearing contact lenses?

Are you allergic to/have you had any reactions to the following?
☐ Local Anesthetics (e.g. Novocam)
☐ Penicillin or any other Antibiotics
☐ Sulfa Drugs
☐ Barbiturates
☐ Sedatives
☐ Iodine
☐ Aspirin
☐ Any Metals (e.g. nickel, mercury, etc.)
☐ Latex Rubber
☐ Other (please list) _____
_____

☐ Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)

Women Only
☐ Are you pregnant or thing you may be pregnant?
☐ Are you nursing?
☐ Are you taking oral contraceptives?

Do you have or have you had any of the following?

☐ High Blood Pressure
☐ Heart Attack
☐ Rheumatic Fever
☐ Swollen Ankles
☐ Fainting/Seizures
☐ Asthma
☐ Low Blood Pressure
☐ Epilepsy/Convulsions
☐ Leukemia
☐ Diabetes
☐ Kidney Diseases
☐ AIDS or HIV Infection
☐ Thyroid Problem

☐ Heart Disease
☐ Cardiac Pacemaker
☐ Heart Murmur
☐ Angina
☐ Frequently Tired
☐ Anemia
☐ Emphysema
☐ Cancer
☐ Arthritis
☐ Joint Replacement or Implant
☐ Hepatitis/Jaundice
☐ Sexually Transmitted Disease
☐ Stomach Troubles/Ulcers

☐ Chest Pains
☐ Easily Winded
☐ Stroke
☐ Hay Fever/Allergies
☐ Tuberculosis
☐ Radiation Therapy
☐ Glaucoma
☐ Recent Weight Loss
☐ Liver Disease
☐ Heart Trouble
☐ Respiratory Problems
☐ Mitral Valve Prolapse
☐ Other _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insorance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
signature of patient (or parent/guardian if minor)

Doctor's Comments _____
_____

Signature _____ Date _____

MINT DENTAL