



Patient's Last Name	First Name	Date of Birth
---------------------	------------	---------------

Please circle the correct response (Yes, No or Don't know); answer all questions.

The following questions are for our records only and will be considered confidential information.

MEDICAL HISTORY
following:

Do you have or have you had in the past any of the

- | | | | |
|--|-------|-------------|--------------|
| 1. Congenital Heart Defects/Abnormalities | Yes | No | Don't know |
| 2. Hypertension (high blood pressure)? | Yes | No | Don't know |
| 3. Heart attack, irregular heart rate, damaged heart valves or angina? | Yes | No | Don't know |
| 4. Stroke or TIA? | Yes | No | Don't know |
| 5. Chest pain or shortness of breath on exertion? | Yes | No | Don't know |
| 6. Swollen ankles? | Yes | No | Don't know |
| 7. Blood disorders such as anemia or hemophilia? | Yes | No | Don't know |
| 8. Frequent nosebleeds, increased bruising or bleeding? | Yes | No | Don't know |
| 9. Pacemaker/ Implanted defibrillator? | Yes | No | Don't know |
| 10. Heart Disease/ Surgery? | Yes | No | Don't know |
| 11. Prosthetic (Artificial) Heart Valve? | Yes | No | Don't know |
| 12. Asthma, tuberculosis or hay fever? | Yes | No | Don't know |
| 13. Emphysema/ Bronchitis? | Yes | No | Don't know |
| 14. Bone Marrow or Organ transplant? | Yes | No | Don't know |
| 15. Lupus or Autoimmune disease? | Yes | No | Don't know |
| 16. Hives or a skin rash? | Yes | No | Don't know |
| 17. Have you ever had a reaction to any drugs (including local anesthetics)? | Yes | No | Don't know |
| If yes, which drugs? _____ | | | |
| 18. Do you have any allergies to MEDICATIONS? | Yes | No | Don't know |
| 19. Do you have a LATEX allergy? | Yes | No | Don't know |
| 20. Are you immunosuppressed (subject to frequent infections)? | Yes | No | Don't know |
| 21. Have you been told you have AIDS, or an HIV positive test? | Yes | No | Don't know |
| 22. Ulcers, stomach or intestinal problems? | Yes | No | Don't know |
| 23. Hepatitis (jaundice) or liver disease? | Yes | No | Don't know |
| 24. Kidney disease or Renal Dialysis? | Yes | No | Don't know |
| 25. Diabetes (high blood sugar)? | Yes | No | Don't know |
| 26. Thyroid Disease? | Yes | No | Don't know |
| 27. Tendency to faint, have convulsions, seizure or epilepsy? | Yes | No | Don't know |
| 28. Do you now or have you ever used tobacco products? | Yes | No | Don't know |
| If yes, are you interested in quitting? | | | |
| 29. How many alcohol drinks do you consume a day? | _____ | Week? _____ | Month? _____ |
| 30. Do you use any recreational drugs? | Yes | No | Don't know |
| If yes, What type? _____ How often? _____ | | | |

EXAMINER'S COMMENTS

MEDICAL HISTORY

31. Are you taking ANY medications now? Yes No Don't know
If Yes, please list the prescription drugs and non-prescription drugs

32. Have you had any eye, ear, nose or sinus problems? Yes No Don't know
33. Snoring or sleep apnea (breathing cessation while sleeping)? Yes No Don't know
34. Arthritis (painful, swollen joints)? Yes No Don't know
35. Have you ever had an artificial joint placed? Yes No Don't know
36. Cancer, chemotherapy or radiation therapy? Yes No Don't know
37. Venereal disease (syphilis, gonorrhea, herpes or other)? Yes No Don't know
38. A blood transfusion? Yes No Don't know
39. Been hospitalized, had major surgery or been seriously hurt? Yes No Don't know
40. Are you pregnant? Yes No Don't know
41. Are you taking oral contraceptives? Yes No Don't know
(Antibiotics can render oral contraceptives ineffective)
42. Are you or have you in the past received psychiatric treatment? Yes No Don't know
43. Are you being treated by a physician now? Yes No Don't know
If Yes, for what condition? _____

44. Please write your physician's name, address and phone:

45. Please list all major surgeries or hospitalizations.

46. Are you in good health? Yes No Don't know
47. Do you have any further information, not already mentioned you think may
be helpful to us in providing your care? Yes No Don't know

If Yes, please specify: _____

EXAMINER'S COMMENTS

AUTHORIZATION: (Please read the following information carefully) I grant authority to the dentists to perform procedures & treatment. I/We agree to pay a finance charge of 1.5% per month (annual rate of 18%) on unpaid balance after 90 days & up to 100% of collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit; authorize release of any information relating to dental treatment & claims; agree to be responsible for payment of services not covered by insurance. I hereby authorize payment of all dental ins. benefits directly to: Excellence in Dentistry-Drs. Kent & Curtis Godfrey. *I certify that to the best of my knowledge, the above information is complete and accurate. If there is a change in my medical/dental history, I will make my provider aware as soon as possible.* **HIPAA Acknowledgement: Upon request I will be given a copy of this office's "Notice of Privacy Practices."**

Patient's signature _____ Date _____

Examiner's signature _____ Date _____

Review & Update FOLLOWING YEAR

Patient's signature _____ Date _____