4b MEDICAL HISTORY

Your Current Physical Condition ❑ Good ❑ Fair ❑ Poor
Do you use tobacco in any form? ❑ Yes ❑ No
Are you taking any over-the-counter/prescription or herbal supplement drugs? ❑ Yes ❑ No
Please List Each One _____
_____
Have you ever taken Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin) If yes, when? _____
Have you ever taken any bone density medications? (Fosamax, etc.) ❑ Yes ❑ No If yes, when? _____
Has your doctor ever told you that you require antibiotics prior to dental treatment? ❑ Yes ❑ No

FOR WOMEN ONLY

Are you taking birth control medications? ❑ Y ❑ N
Are you pregnant? ❑ Yes ❑ No Week # _____
Are you nursing? ❑ Yes ❑ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Cold Sores/Fever Blisters
Yes	No	Drug/Alcohol Abuse	Yes	No	High Blood Pressure
Yes	No	Anemia	Yes	No	HIV / AIDS
Yes	No	Arthritis	Yes	No	Hospitalized for any reason
Yes	No	Artificial Bones, Joints or Valves	Yes	No	Kidney Problems
Yes	No	Asthma	Yes	No	Liver Disease
Yes	No	Blood Transfusion	Yes	No	Low Blood Pressure
Yes	No	Cancer/Chemotherapy	Yes	No	Lupus
Yes	No	Colitis	Yes	No	Mitral Valve Prolapse
Yes	No	Congenital Heart Defect	Yes	No	Pacemaker
Yes	No	Diabetes	Yes	No	Psychiatric Problems
Yes	No	Difficulty Breathing	Yes	No	Radiation Treatment
Yes	No	Emphysema	Yes	No	Rheumatic/ Scarlet Fever
Yes	No	Epilepsy			
Yes	No	Fainting Spells	Yes	No	Seizures
Yes	No	Frequent Headaches	Yes	No	Shingles
Yes	No	Glaucoma	Yes	No	Sickle Cell Disease
Yes	No	Hay Fever	Yes	No	Sinus Problems
Yes	No	Heart Attack	Yes	No	Stroke
Yes	No	Heart Murmur	Yes	No	Thyroid Problems
Yes	No	Heart Surgery	Yes	No	Tuberculosis (TB)
Yes	No	Hemophilia	Yes	No	Ulcers
Yes	No	Hepatitis	Yes	No	Veneral Disease

Please list any other medical condition(s) that you have had:
_____
_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

Please list any other drugs/materials that you are allergic to:
_____
_____

5 DISCLAIMER

For 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 the dental office of any changes in medical status. The undersigned hereby authorizes Doctor, in order to make a thorough diagnosis of the patient's dental needs, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor. I understand that the Doctor will advise me of any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____. I also understand that the Doctor may choose and employ such assistance as deemed fit. I further understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time that services are rendered unless financial arrangements have been previously made. I further understand that I am entitled to a 5% courtesy if payment for services is made within 24 hours. All other financial arrangements, insurance, credit cards, or time payments, are not subject to that courtesy. A 1 ½ % monthly finance charge will be applied to all accounts over 60 days past due. There will be a $25.00 service charge on all returned checks. We require 24 hours notice for cancellations. If a 24 hour notice is not given, it will be necessary to charge $30.00 for each appointment cancelled. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____
Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

OAKVILLE DENTAL CARE

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____
Doctor's comments _____
_____