MEDICAL HISTORY

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Patient Name_____ Nickname_____Age_____

Name of Physician_____Approximate date of last physical exam_____

What is your estimate of your general health? Excellent Good Fair Poor

Are you allergic to any of the following? (Please circle)

Aspirin Codeine Fluoride Penicillin Acryllic Latex Metals

Are you allergic to any other medications?_____

Have you ever had an adverse reaction to dental anesthetic? Yes No

DO YOU HAVE OR HAVE YOU EVER HAD:

Heart Disease such as High Blood Pressure, Heart Attack, Stroke, Angina, Artificial Valve, Congenital Heart Disease, Heart Surgery, Pacemaker	YES NO
Lung Disease such as: Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath	YES NO
Seizures, convulsions, epilepsy, fainting or dizziness	YES NO
Sleep Apnea, C-PAP	YES NO
Bleeding Disorder, Anemia, Bruise Easily	YES NO
Liver Disease (Jaundice, Hepatitis)	YES NO
Kidney Disease	YES NO
Diabetes	YES NO
Thyroid Disease	YES NO
Arthritis	YES NO
Stomach Problems (Ulcers, Colitis, Acid Reflux)	YES NO
Glaucoma	YES NO
Artificial Joints or Implants Anywhere In Your Body (Hip,Knee)	YES NO
Diagnosis or Treatment for Cancer (Chemo or Radiation)	YES NO
Sinus or Nasal Problems	YES NO
Have you ever taken a Bisphosphonate Drug (Fosamax, Zometa, Boniva, Actonel or Reclast injection)	YES NO

Please list any serious illness not listed above, current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

_____

_____

Women: Are you

Pregnant/Trying to get pregnant YES NO

Taking oral contraceptives? YES NO

Nursing? YES NO

Please turn over and continue

Have you ever been hospitalized or had surgery? Yes No Date: _____
If yes, please explain_____

Are you on a special diet or had recent weight loss or gain? Yes No
If yes, please explain_____

Please list *any and all medications*, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins or minerals that you are currently taking.

Drug (example: Atenolol)	**Purpose** (example: blood pressure)	**Drug** (example: Atenolol)	**Purpose** (example: blood pressure)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The undersigned hereby authorizes Scott Nicholson, DMD, to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for DentalServices provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% financial charge (18% annually) will be added to any balance over 60 days. 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.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient _____