



- | Yes                      | No                       |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hyper (Hypo) Glycemia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension            |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease          |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease            |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignant Hyperthermia  |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental/nervous disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse   |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant        |

- | Yes                      | No                       |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Medical implant         |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment   |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic/Scarlet fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell disease     |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach problems        |
| <input type="checkbox"/> | <input type="checkbox"/> | Intestinal problems     |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                  |

- | Yes                      | No                       |                  |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis     |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers           |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____      |
| <input type="checkbox"/> | <input type="checkbox"/> |                  |
| <input type="checkbox"/> | <input type="checkbox"/> |                  |

23. Has the **CHILD PATIENT** *recently* had any of the following: (indicate approximate date)

- |                          |                          |             |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Measles     |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps       |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox |

- |                          |                          |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Strep throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____  |

24. **WOMEN ONLY** Are you pregnant or suspect you may be?    
 If yes, what is the expected delivery date? \_\_\_\_\_ Are you taking birth control pills? yes  no

25. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?  
 yes  no  \_\_\_\_\_

26. Is there anything else about your health we should be made aware of? \_\_\_\_\_

27. Do you wish to speak to the Doctor privately about any problem or medical condition? yes  no

**NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.**

## GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents in mine, and I assume responsibility for fees associated with these services.

X \_\_\_\_\_

PATIENT  PARENT  GUARDIAN

(PRINT NAME OF GUARDIAN)

Doctor's comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reviewed by Treating Dentist: \_\_\_\_\_ Date: \_\_\_\_\_