JOLLY FAMILY DENTISTRY

MEDICAL HISTORY

PATIENT NAME

BIRTH DATE

Although dental primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Yes No Are you under a physician's care now? If yes explain:
Yes No Have you ever been hospitalized or had a major operation? If yes explain:
Yes No Have you ever had a serious head or neck injury? If yes explain:
Yes No Are you taking any medications, pills, or drugs? If yes explain:
Yes No Are you on a special diet? If yes explain:

Women: Are you
Pregnant/Trying to get pregnant? Nursing?
Taking oral contraceptives?

Yes No Do you use tobacco?
Yes No Do you use controlled substances?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes explain:

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

AIDS/HIV Positive	Chest Pains	Frequent Headache	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/ Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heat Trouble/Disease	Pain in Jaw Joints	Sulfa Drugs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Swelling of Limbs
Blood disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Thyroid Disease
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tonsillitis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizzines	High blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Couch	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemic	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes please explain

Comments:

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 rendered to me or my child during the period of such dental care to third party payers and/ or health practitioners. I authorize and request my insurance

MEDICAL HISTORY

company to pay directly to the dentist or dental group insurance benefits or 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. I acknowledge that I have reviewed a copy of Jolly Family Dental's Notice of Privacy Practices