Today's date___________________________

HEALTH INFORMATION and MEDICAL HISTORY

PATIENT NAME ____ **Date of Birth** ___________________________

Physician's Name ____ **Physician's Phone #** ____________________

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Please answer the following questions as completely as possible. (Circle "YES" or "NO")

1. Have you been hospitalized during the past year? YES NO
   If yes, please explain: ____

2. Are you currently under a doctor's care for other than routine visits? YES NO
   If yes, please list condition(s) being treated: ____

3. Do you take any medications, including birth control, on a regular basis? YES NO
   If yes, please list the medications: ____

   ____

4. Have you taken a biophosphonate medication like FOSAMAX, AREDIA, ZOMETA, or ACTONEL? YES NO

5. Do you have, or have you ever had, any heart or blood problems, including heart murmur? YES NO
   If yes, please explain: ____

6. Do you require antibiotic <u>PRE-MEDICATION</u> for a heart condition, artificial valve, or artificial joint? YES NO

7. Do you have, or have you previously had, high blood pressure? YES NO

8. Have you ever been diagnosed as being HIV positive, or having AIDS? YES NO

9. Have you ever had any of the following? (Please place a check mark where applicable) YES NO

   Rheumatic fever ____ Asthma ____ Diabetes ____
   Blood disorder ____ Heart Attack ____ Arthritis ____
   Tuberculosis ____ Kidney Disease ____
   Venereal disease (STD) ____ Other disease(s)____
   Immune system disorder____ **Please specify:_____________________________

10. Have you ever had an unusual reaction, to or are you allergic to, any of the following medications? YES NO
    (Please place a check mark where applicable)

    Penicillin ____ Aspirin ____
    Ibuprofen ____ Sulfa drugs ____
    Codeine ____ Acetaminophen ____
    Barbiturates ____ (Tylenol)
    Other medications** ____
    **Please specifiy: ____ YES NO

11. Do you have other types of allergies not listed above? YES NO
    If yes, please list; ____

12. Have you ever had hepatitis? If yes, which type? (A,B,C) ________________ YES NO

HEALTH INFORMATION, continued

13.	Have you ever had any severe reaction to dental treatment, or to local anesthetics? If yes, please describe: ______________________________	YES	NO
14.	Do you use tobacco products?	YES	NO
15.	Have you ever received counseling for excessive use of alcohol and/or prescription drugs?	YES	NO
16.	Do you have, or have you ever had, bleeding or sensitive gums?	YES	NO
17.	Do you bleed or bruise easily?	YES	NO
18.	Women: Are you pregnant now? If YES, please list due date ______________________________	YES	NO
19.	When did you last see a dentist? ______________________________		
20.	Who was your previous dentist? ______________________________		
21.	Do you have any specific concerns or issues that you would like discussed today? If yes, please specify: ______________________________ ______________________________	YES	NO

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED WITH TREATMENT:

I CERTIFY THAT THE ANSWERS TO THE HEALTH AND MEDICAL QUESTIONS ABOVE ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE CHANGES IN MEDICAL CONDITIONS OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF, AND AGREE TO NOTIFY THE DENTIST OF, ANY CHANGES IN MY HEALTH AT FUTURE APPOINTMENTS.

I authorize Dr. Michael B. Hill and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor child or other individual(s) for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharma- ceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising; hematoma; cardiac stimulation; temporary, or rarely, permanent numbness; and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful, both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit (or the benefit of my minor child or ward). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary, and I have been given the opportunity to ask questions.

SIGNATURE ______________________________ DATE ______________________________
(Patient, legal guardian, or authorized agent of patient)

WITNESS ______________________________ DATE ______________________________