Medical/Dental History

Name ______________________________

Family Physicians Name ______________________ Phone ________________

Are you receiving any health care now? Yes No Are you taking any medication? Yes No

If you have had or have now any of the following please check:

	Yes	No
Heart Condition:		
Abnormal blood pressure	☐	☐
Artificial valve or joint	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Stroke	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
High cholesterol	☐	☐
Prolonged bleeding	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Glaucoma	☐	☐
Hepatitis	☐	☐
Sinus problems	☐	☐
TB (tuberculosis)	☐	☐
Kidney problems	☐	☐
Stomach or intestinal problems	☐	☐
Arthritis	☐	☐
Venereal Disease	☐	☐
HIV positive	☐	☐
Smoke or chew tobacco	☐	☐
Allergies:		
Penicillin	☐	☐
Local anesthetic	☐	☐
Codeine	☐	☐
Other	☐	☐
Women:		
Are you pregnant?	☐	☐

Previous Dentist Name ______________________ Phone ________________

Is your mouth sensitive to? (Circle) Hot Cold Sweet Chewing

	Yes	No
Do you have any pain or clicking upon opening or closing your jaw?	☐	☐
Are you aware of any clenching or grinding of your teeth?	☐	☐
Have you been treated for periodontal disease (gum disease)?	☐	☐
Have you had orthodontic treatment?	☐	☐

Notes: ____

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Release of Information & Consent of Treatment

I hereby authorize release of any information, including the diagnosis and records of treatments or examinations rendered, to my insurance company or companies. I hereby authorize payment of any insurance benefit, that otherwise would go to me, directly to Dr. Austin. I understand that I am responsible for payment of dental services provided in this office for my dependents or myself. All outstanding balances over 90 days shall accrue interest at a rate of 1.5% per month. I hereby grant authority to Dr. Austin and/or staff in charge of the patient whose name appears on this history form, to administer any treatment and any such x-rays, anesthetic or nitrous oxide sedation, which may be deemed necessary or advisable in the treatment of this patient.

Signature ______________________ Date __________ Relationship to patient ________