ALLERGIES? (Circle) *YES / NO* **PLEASE LIST**____

(Penicillin, Codeine, Latex, Sulfites, etc…)

CIRCLE IF YOU HAVE **NOW** OR HAVE **EVER** HAD ANY OF THE FOLLOWING:

AIDS—HIV	Kidney Problems	Stroke	Allergies/Hay fever
ADD/ADHD	Chemical Dependency	Arthritis	Daily Fluoride Tablets
Thyroid Problems	Nervous Problems	Cancer	Fainting
Sinus Problems	Cold Sores	Hepatitis	Ulcers
Epilepsy	Bleeding Problems	TB	Heart Murmur
Lung Problems	Chicken Pox	Hives	Pacemaker
Diabetes	Liver Problems	Osteoporosis	Heart/Blood Problems
Implants	Mitral Valve Prolapse	Bisphosphonate	Rheumatic Fever/Heart
Asthma	HI/LOW Blood Pressure	Artificial Valves, Limbs or Joints	

Do you currently use tobacco or tobacco like products (Vape)? ____________________________

Do you use any recreational drugs? ____

(WOMEN) ~If you are pregnant, when is your due date? ________________________________

~Are you taking hormones or birth control? ___________________________________

Is there anything you want us to know about your health?

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AUTHORIZATION, RELEASE AND CONSENT FOR TREATMENT:

I certify that I have read and answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care, to third party payers and or health practitioners. I hereby give my consent for any preventive and/or restorative treatment that the dentist and I have deemed necessary. I authorize and request my insurance company to pay directly to the dentist, insurance benefits 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.

X____Date____________________

Signature of Patient or Parent

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE OR PROVIDE A CURRENT COPY TO ATTACH

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HEALTH HISTORY REVIEW SIGNATURE AND DATE BY DR/RDH___________________________________