

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing for your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Last Visit: _____

Address: _____ Phone: _____

Have you ever experienced any health problems? No Yes Explain: _____

Any major change in your health recently? No Yes Explain: _____

Are you currently under physician's care? No Yes Explain: _____

Are you currently taking medications? No Yes Explain: _____

Are you allergic to any medications? No Yes Explain: _____

Have you received a blood transfusion? No Yes Explain: _____

Have your tonsils or adenoids been removed? No Yes Explain: _____

Have you been in a risk group for AIDS? No Yes Explain: _____

Are you pregnant? No Yes # months _____

Do you smoke? No Yes How much: _____

Have you **ever** taken Bisphosphonate drugs? No Yes When? _____ Why? _____

(Examples of Bisphosphonates = Fosamax, Didronel, Boniva)

Please circle if you have had any of the following conditions:

Heart Murmur	No	Yes	Hepatitis	No	Yes	Emotional Problems	No	Yes
Heart Surgery	No	Yes	Diabetes	No	Yes	Frequent Headaches	No	Yes
Rheumatic Fever	No	Yes	Kidney Disease	No	Yes	Nervous/Anxious	No	Yes
Endocrine Disorders	No	Yes	Liver Disease	No	Yes	Cancer	No	Yes
Prolonged Bleeding	No	Yes	Tuberculosis	No	Yes	Bone Disorders	No	Yes
Anemia	No	Yes	Bronchitis	No	Yes	Growth Disorders	No	Yes
Blood Disease	No	Yes	Asthma	No	Yes	Mouth Breather	No	Yes
Developmental Disorder	No	Yes	Epilepsy	No	Yes	Herpes (Fever Blisters)	No	Yes
Hives/Rash	No	Yes	Fainting	No	Yes	Latex Allergy	No	Yes

Any other health problems or special concerns: _____

Comments: _____

INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services rendered are charged directly to the patient and the patient, parent and/or guardian are responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company. In order to do so, please sign below authorizing Dr. McDonough's office to provide each respective insurance company, claim administrator and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This form also authorizes release of any information relating to a claim submitted on your behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one of more credit reporting services.

I have read and understand the above questions. If there are any changes later to this history record or medical/dental status I will inform this practice.

Patient's Signature: _____ Date: _____

For Future Use	Changes since last history: _____

	Signature: _____ Date: _____