**Health Questions/Medical History**

Yes No Is your general health good?

Yes No Do you have any allergies to food, medication, metals, etc?

If yes, which ones?_____

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

Yes No Heart trouble

Yes No Rheumatic fever

Yes No Heart murmur

Yes No HIV of AIDS

Yes No Asthma

Yes No Antidepressant medications

Yes No Bleeding problems

Yes No Diabetes

Yes No Epilepsy

Yes No Hepatitis

Yes No Mitral valve prolapse

Yes No Leaky heart valve

Yes No Infective endocarditis

Yes No Artificial (prosthetic) heart valve or valves

Yes No Radiation therapy

Yes No Females: Are you pregnant?

Yes No Are you sensitive or allergic to latex?

Yes No Are you able to take Aspirin, Aleve, Ibuprofen or Motrin?

Is there any other information about your health which should be known?

_____

_____

_____

Please list all current medications_____

Patient Name _____

X_____Date_____

*Signature (patient or parent if minor)*

I authorize the use of my radiographs and/or photographs for use in seminars or publications of the doctor.

X_____Date_____

*Signature (patient or parent if minor)*

I understand that as a service to me, the dental practice will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

X_____Date_____

**ONLY if you have insurance SIGNATURE ON FILE**

So you don't have to sign an insurance form at each dental visit, we will maintain this "signature on file" for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize my Provider, insurer or other Organization to release my information regarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X_____

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to the doctor for services rendered.

X_____Date_____