MEDICAL HISTORY

Name: _____ **DOB:** _____
Last First MI

PRIMARY CARE PHYSICIAN: Name, phone & city _____

EMERGENCY CONTACT: (**name & phone #** of person not residing with you) _____

Please CIRCLE any condition you HAVE or are RECEIVING TREATMENT or MEDICATION.

*PRE-MED	ADD/ADHD	Allergies: Other Med
Allergies: Seasonal	Allergy: Codeine	Allergy: Iodine
Allergy: Latex	Allergy: Metal	Allergy: PEANUT/NUT
Allergy: Penicillin	Allergy: Sulfa	Allergy: Local Anesthetic
Alzheimer's Disease	Anemia	Anxiety/Depression
Arthritis	Artificial Joints	Aspirin taken daily
Asthma	Autism	Bisphosphonates
Blood Disease	Blood Thinning Meds	Cancer
Diabetes	Digestive/Stomach/Ulcer	Dizziness/Fainting
Drug Abuse History	Epilepsy/Seizures	Excessive Bleeding
Glaucoma	Growths/Tumors	Head Injuries
Heart Disease	Heart Murmur	Heart Pacemaker
Heart Valve Surgery	Hepatitis	High Blood Pressure
HIV+/AIDS	Hormone Therapy	Kidney Disease
Liver Disease	Low Blood Pressure	Lupus
Mitral Valve Prolapse	Neurological/Parkinson's	Oral Contraceptives/BCPs
OTHER: *Explain below	Pregnancy	Psychiatric Disorders
Radiation/Chemo Tx	Respiratory Problems	Rheumatic Fever
Rheumatism	Sinus Problems	Stroke
Thyroid Disorders	Tobacco: Smoke/Chew	Tuberculosis

Please note any OTHER HEALTH CONDITIONS, ALLERGIES, or SURGERIES. Please also provide further explanation, if needed, for any conditions indicated on the other side of this form.

_____

_____

_____

_____

Please list ALL MEDICATIONS you take INCLUDING ANY OVER THE COUNTER MEDICATIONS.

WOMEN: Are you pregnant? Yes No

AUTHORIZATION:

I hereby certify that I have read and understand the previous information and that I have provided a true and accurate medical history to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment without fail or sooner if I should call the office with a medical or dental concern or question.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. Upon such diagnosis I authorize Dr. Guebert or his associates or staff to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks and that I may ask for an explanation of possible risks.

I will not hold Dr. Guebert or any member of his staff responsible for any errors or omissions that may have been made in the completion of this form.

_____ _____

PRINT Patient Name Date

_____ Relationship to Patient if other than self: _____

Signature