Emerald Valley Dental

Patient Medical History

Are you currently under medical Treatment?
If yes please explain: _____
_____
_____
_____
_____

Have you been hospitalized for any surgical operations or serious illness within the last year?
If yes please explain: _____
_____
_____
_____
_____
_____

Do you have any allergies to medications?
_____
_____
_____
_____
_____

Are you taking any bone enhancing drugs?
(Ex. Fosamax, Boniva)
_____
_____

Do you use Tobacco? _____
If yes what type: _____
_____
How frequently? _____
_____

Women Only:
Are you pregnant? _____
Are you nursing? _____
Are you taking oral contraceptives? _____

Do you have a history of cold sores? Yes No

Please complete the following. If yes to any please write year of incident:

Heart attack: _____
Heart Disease: _____
Heart Murmur: _____
Rheumatic Fever: _____
Joint Replacement or Implant: _____
Have you ever been told you need an antibiotic pre-med for a dental appointment? Yes No
Infective Endocarditis: _____
Mitral Valve Prolapse: _____
Stroke: _____
High Blood Pressure: _____
Cardiac Pacemaker: _____
Angina: _____
Fainting/Seizures: _____
Epilepsy/Convulsions: _____
Anemia: _____
Emphysema: _____
Cancer: _____
Type: _____
Arthritis: _____
Asthma: _____
Tuberculosis: _____
Liver Disease: _____
Hepatitis: A B C _____
Ulcers: _____
Kidney Disease: _____
AIDS or HIV: _____
Thyroid Problem: _____
Psychiatric Condition: _____
Hemophilia/Bleeding Disorders: _____
Diabetes, if yes what type: _____
Glucose level for the morning: _____
Other: _____
None: _____

Are you taking any medications or drugs?

If yes please list below:

	Name of Drug	How often (frequency)	Reason for taking medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and results of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable by me. I understand that my dental insurance 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 department.

Signature_____

Print Name_____

Date_____