**PATIENT’S MEDICAL HISTORY**

Are you currently under a physician’s care? Yes\_\_\_ No\_\_\_

Do you have a medical condition that requires you to take antibiotics prior to dental treatment? Examples are: Joint or Heart Valve Replacement? Yes\_\_\_ No\_\_\_

Are you currently taking a Prescription **Blood Thinner** (i.e., Coumadin, Plavix)? Yes \_\_\_ No \_\_\_

Are you currently taking **Aspirin**? Yes\_\_\_No\_\_\_

**Please check yes or no if you have had or suspected:**

Y\_\_\_N\_\_\_ Heart Trouble

Y\_\_\_N\_\_\_ Heart Attack (Date\_\_\_\_\_\_)

Y\_\_\_N\_\_\_ Heart Murmur/Leaky Valve

Y\_\_\_N\_\_\_ Prosthetic Heart Valve (Date\_\_\_\_\_\_)

Y\_\_\_N\_\_\_ Chest Pain

Y\_\_\_N\_\_\_ Shortness of Breath

Y\_\_\_N\_\_\_ Bypass (date\_\_\_\_\_\_)

Y\_\_\_N\_\_\_ High Blood Pressure

Y\_\_\_N\_\_\_ Stroke (date\_\_\_\_\_\_)

Y\_\_\_N\_\_\_ Prosthetic/Artificial Joint (\_\_\_Date\_\_\_)

Y\_\_\_N\_\_\_ Liver Disease

Y\_\_\_N\_\_\_ Hepatitis

Y\_\_\_N\_\_\_ Kidney Disease

Y\_\_\_N\_\_\_ Dialysis

Y\_\_\_N\_\_\_ Cancer/Tumor

Y\_\_\_N\_\_\_ Immunocompromised

Y\_\_\_N\_\_\_ Diabetes

Y\_\_\_N\_\_\_ Asthma

Y\_\_\_N\_\_\_ Bleeding Problems

Y\_\_\_N\_\_\_ Epilepsy

Y\_\_\_N\_\_\_ Tuberculosis

Y\_\_\_N\_\_\_ Thyroid

Y\_\_\_N\_\_\_ Reflux/GERD

Y\_\_\_N\_\_\_ Stomach Ulcer

Y\_\_\_N\_\_\_ Hiatal Hernia

Y\_\_\_N\_\_\_ Blood Transfusion

Y\_\_\_N\_\_\_ Arthritis

Y\_\_\_N\_\_\_ Back/Neck Problems

Y\_\_\_N\_\_\_ Glaucoma

Y\_\_\_N\_\_\_ Sinus Problems

If yes, Location \_\_\_\_\_\_\_\_, Date Treated \_\_\_\_\_\_\_\_

**Allergies:** List any Medication Allergies/Sensitivities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to **LATEX?**  Y\_\_\_N\_\_\_

**Please** list any **Medications** you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doyou have any problems with your TMJ/TMD (Jaw Joint)? Y\_\_\_N\_\_\_

Other health information not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women:** Are you pregnant? \_\_\_\_If yes, how many months? \_\_\_\_ Breastfeeding? \_\_\_\_ Taking Birth Control? \_\_\_\_

**PATIENT’S EXPLANATION**

We ask that your balance be paid by your last appointment. Please advise our receptionist if other arrangements are necessary. We accept cash, personal checks on local banks, money orders, most major credit cards.

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

**Lawrence C. Walsh, D. D. S. – Steven E. Fegan, D. D. S., M. S. – Derik P. DeConinck, D. D. S.,**

**I agree to be responsible for any charges not paid by my insurance company including all accident claims.**

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 **SIGNED (PATIENT OR PARENT IF MINOR) DATE**