MEDICAL HISTORY

Patient's Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No _____

Do you take or have you ever taken bone building drugs such as Fosamax and Boniva? ❍ Yes ❍ No _____

Are you on a special diet? ❍ Yes ❍ No _____

Do you use tobacco? ❍ Yes ❍ No _____

Do you take or have you ever taken antibiotic premedication prior to dental treatment? ❍ Yes ❍ No _____

Do you use recreational or street drugs? ❍ Yes ❍ No _____

Are you taking any medication, supplements, or prescription drugs? ❍ Yes ❍ No _____

If yes, please list _____

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicilin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other (Please specify) _____

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Heart Murmur'	☐ Mitral Valve Prolapse*
☐ Alzheimer's Disease	☐ Diabetes Type I	☐ Heart Pace Maker*	☐ Osteoporosis/Osteopenia
☐ Anaphylaxis	☐ Diabetes Type II	☐ Heart Trouble/Disease	☐ Parathyroid Disease
☐ Anemia	☐ Drug Addiction	☐ Hemophilia	☐ Psychiatric Care
☐ Angina	☐ Easily Winded	☐ Hepatitis A	☐ Radiation Treatments
☐ Arthritis/Gout	☐ Emphysema	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ Artificial Heart Valve*	☐ Epilepsy or Seizures	☐ Herpes	☐ Rheumatic Fever*
☐ Artificial Joint*	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Scarlet Fever
☐ Asthma	☐ Excessive Thirst	☐ Hives or Rash	☐ Shingles
☐ Blood Disease	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Sinus Trouble
☐ Breathing Problems	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Stomach/Intestinal Disease
☐ Cancer	☐ Frequent Diarrhea	☐ Jaundice	☐ Stroke
☐ Chemotherapy	☐ Frequent Headaches	☐ Kidney Problems	☐ Swelling of Limbs
☐ Chest Pains	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Disease
☐ Cold Sores/Fever Blisters	☐ Hay Fever	☐ Low Blood Pressure	☐ Tuberculosis
☐ Congenital Heart Disorder	☐ Heart Attack/Failure	☐ Lung Disease	☐ Tumors or Growths

*Condition may require medication.

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please specify _____

Comments: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me 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 to me. I understand that my dental insurance carrier 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 dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Signature of Patient, Parent or Guardian Date

SPOKANE VALLEY DENTAL
200 N. Mullan Road, Suite 103 · Spokane, WA 99206
Phone: 509.928.8431 · Fax: 509.928.3522 · E-Mail: info@spokanevalleydental.com

SUBMIT