HEALTH HISTORY AND INFORMATION

1. What is the reason for today's visit? _____

2. Please circle **Yes** or **NO** to each of the following medical conditions you have had or have at the present:

Angina Pectoris............................ **Yes No**	Blood Transfusion.................... **Yes No**	Drug Addiction........................ **Yes No**
Artificial Heart Valve.................... **Yes No**	H.I.V. Positive.......................... **Yes No**	Emphysema........................... **Yes No**
Artificial Joints (Hip, Knee)........... **Yes No**	Hemophilia............................. **Yes No**	Epilepsy or Seizures.............. **Yes No**
Congenital Heart Lesion............... **Yes No**	Hepatitis................................. **Yes No**	Glaucoma.............................. **Yes No**
Heart Disease or Attack............... **Yes No**	Jaundice/ Liver Disease.......... **Yes No**	Kidney Trouble...................... **Yes No**
Heart Murmur............................... **Yes No**	Used Fen-Phen Diet Pills......... **Yes No**	Latex Allergy......................... **Yes No**
Heart Surgery/ Pacemaker........... **Yes No**	Sickle Cell Disease.................. **Yes No**	Pain in the Jaw Joints............ **Yes No**
High Blood Pressure..................... **Yes No**	Allergies/ Hives/ Hay Fever...... **Yes No**	Psychiatric Care.................... **Yes No**
Mitral Valve Proplapse................. **Yes No**	Arthritis.................................. **Yes No**	Sexual Transmitted Disease... **Yes No**
Rheumatic Fever.......................... **Yes No**	Asthma................................... **Yes No**	Sinus Trouble/ Sinusitis......... **Yes No**
Scarlet Fever............................... **Yes No**	Cancer.................................... **Yes No**	Thyroid Disease..................... **Yes No**
Stroke... **Yes No**	Cold Sores/ Fever Blisters....... **Yes No**	Tuberculosis (TB)...................**Yes No**
A.I.D.S.. **Yes No**	Cortisone Medication.............. **Yes No**	Ulcers.................................... **Yes No**
Anemia.. **Yes No**	Diabetes................................ **Yes No**	Other _____

3. Have you ever been hospitalized, or required any type of surgery?.. **YES NO**
   If yes, please explain: _____
   _____

4. Are you currently under the care of a physician? .... **YES NO**
   If yes, please explain: _____
   Your Physician's Name: _____ Phone # _____

5. Are you taking any medication, drugs or pills? .... **YES NO**
   If yes, please list: _____
   _____

6. Are you allergic to or have you ever reacted adversely to any medication or substance?................................. **YES NO**
   If yes, please list: _____
   _____

7. FOR WOMEN ONLY: Are you pregnant?   **YES   NO**   If yes, what month? _____

CONSENT: I certify to the above statements regarding my medical condition. I authorize Drs. Phillips, Jue and/or other dentists in this office to take diagnostic films, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis. I also grant authority to administer or prescribe any dental or emergency treatment and to administer such medicines, anesthetics, antibiotics, etc. as may be deemed necessary or advisable in the diagnosis or treatment of my condition. I also understand the use of anesthetic agents embodies a certain risk. I further understand that r esponsibility for dental services provided in this office for myself or my dependents is mine. I authorize you to verify all references and credit data. I acknowledge that a complete explanation of this offices' financial policies is available in a Patient Information brochure.

PATIENT SIGNATURE: _____DATE: _____

If patient is a child or requires a guardian:
PARENT OR GUARDIAN'S SIGNATURE: _____ DATE: _____

Medical Review:
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____
      Date: _____ Dr./RDH _____ Changes: YES NO _____