PROACTIVE DENTAL

Health History Update

It is required by State Law to update Medical History every 6 months

Are you taking any of the following medications? () Nerve Pills () Tranquilizers () Pain Killers (including Aspirin) () Muscle Relaxers () Stimulants () Blood thinners () Insulin Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions or procedures? Please check all that applies.

() Heart Attack/ Stroke	() Thyroid Problem	() Cancer/Tumors	() Heart Surg/Pacemaker
() Kidney Problems	() Shingles	() Heart Murmur	() Liver Problems
() Hepatitis	() Rheumatic Fever	() Respiratory Problem	() HIV+/AIDS/ARC
() Mitral Valve Prolaps	() Sinus Problems	() Arthritis/Rheumatism	() Artificial Valves
() Stomach Prob./Ulcer	() Artificial Bones/Joints	() Heart Disease	() Psychiatric Problems
() Emphysema	() Congenital Heart	() Venereal Disease	() Fainting/Seizures/Epilepsy
() Chest Pains	() Alcohol Drug Abuse	() Severe/Frequent Headaches	() Scarlet Fever
() Tuberculosis TB	() Frequent Neck Pain	() Nervousness	() Jaw Problems/TMJ/TMD
() Back Problems	() Cosmetic Surgery	() Xray or Cobalt Treatment	() Chemotherapy
() Asthma	() Difficulty Breathing	() Diabetes/Hypoglycemia	() Leukemia
() Anemia	() High/Low Blood Pressure	() Bleeding problems	() Glaucoma () Scoliosis

Please list any other medical conditions or other surgeries you have or ever had:_____
Are you allergic to any of the following? () Latex () Penicillin/Amoxicillin () Aspirin () Tetracycline
() Dental Anesthetics () Others:_____

Do you use tobacco? No Yes How used?_____How much?_____How long?_____
Have you ever taken Phen-fen and or Redux? Yes No Do you wear contact lenses? Yes No
Please rate your general health from 1-10:_____ IS THERE ANYTHING IN PARTICULAR THAT YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR REGARDING YOUR TEETH?_____

For Women: Are you taking Birth Control Pills? Yes No How many children have you had?_____
Are you pregnant? No Yes/How long?_____Are you nursing? Yes No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been mad with the business manager. If account is not paid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____Date___/___/___Staff _____Date___/___/___
() Adult Patient () Parent/Guardian () Spouse