

**Maricopa Fiesta Dental Care
MEDICAL HISTORY**

CIRCLE

Are you having pain or discomfort at this time YES NO
 Have you been a patient in the hospital during the past two years? YES NO
 Have you been under the care of a medical doctor during the past two years? YES NO

Physicians Name _____
 Address _____ Phone # _____

Have you taken any medicine or drugs during the past two years? YES NO
 Are you now taking any medication, drugs or pills? YES NO
 If yes, please list those drugs _____
 Are you taking a bisphosphonate i.e. fosamax, boniva, etc.? YES NO

Are you allergic to any drugs or medicines listed below?

Aspirin	Nitrous Oxide	Valium	Penicillin	Latex
Darvon	Erythromycin	Scopolamine	Other Antibiotics	
Codeine	Tetracycline	Local Anesthetic	(Novocaine or Xylocaine)	
Demerol	Percodan	Nembutal/Seconal	(Sleeping pills)	

Are you aware of being allergic to any other medication or substance? YES NO
 If yes, please list: _____

Circle any of the following which you have had or have at present:

- | | | |
|--------------------------|---------------------------------|--|
| Heart Failure | Emphysema | Artificial Joints (Hip, Knee) |
| Heart Disease or Attack | Cough | Hepatitis A (infectious) |
| Angina Pectoris | Tuberculosis (TB) | Hepatitis B (serum) |
| High Blood Pressure | Asthma | Hepatitis C |
| Heart Murmur | Hay Fever | Liver Disease |
| Rheumatic Fever | Sinus Trouble | Yellow Jaundice |
| Congenital Heart Lesions | Allergies or Hives | Blood Transfusion |
| Scarlet Fever | Diabetes | Drug Addiction |
| Artificial Heart Valve | Thyroid Disease | Hemophilia |
| Heart Pacemaker | X-ray or Cobalt Treatment | Venereal Disease (Syphilis, Gonorrhea, Herpes) |
| Heart Surgery | Chemotherapy (Cancer, Leukemia) | Cold Sores |
| Artificial Valve | Arthritis | Fever Blisters |
| Anemia | Rheumatism | Epilepsy or Seizures |
| Stroke | Cortisone Medicine | Fainting or Dizzy Spells |
| Kidney Trouble | Glaucoma | Nervousness |
| Ulcers | Pain in Jaw Joints | Psychiatric Treatment |
| Bruise Easily | Sickle Cell Disease | |

Have you ever had prolonged bleeding from injury or previous extractions? YES NO
 Have you been exposed to or diagnosed as having A.I.D.S.? YES NO
 Have you lost or gained more than 10 pounds in the past year? YES NO
 Are you on a special diet? YES NO
 Has your medical doctor ever said you have a cancer or tumor? YES NO
 Do you have any disease, condition, or problem not listed? YES NO
 Are you pregnant? Yes No If yes, what month? _____. Are you taking birth control pills? Yes No

I have filled out this health questionnaire completely and I have advised you of all medical problems of which I am aware.

Date: _____

Signature of Patient or Guardian

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient): _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Service provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____
 Parent or Responsible Party _____ Relationship to Patient _____