MEDICAL HISTORY

Silverton FAMILY DENTISTRY

1. Are you currently experiencing pain or discomfort? ..... [Y] YES [N] NO
2. Do you feel very nervous about having dental treatment? ..... [Y] YES [N] NO
3. Have you been hospitalized in the past 2 years? ..... [Y] YES [N] NO
4. Have you been under a doctor's care in the past 2 years? (other than routine) ..... [Y] YES [N] NO

   Nature of care _____ Physician's Name _____
5. Are you currently taking any medications? ..... [Y] YES [N] NO

   If so, please list: _____

   _____
6. Are you allergic to or have a sensitivity to any of the following? Please check the box [Y] YES or [N] NO next to each:

[Y] [N] Latex	[Y] [N] Novacaine	[Y] [N] Other: _____
[Y] [N] Erythromycin	[Y] [N] Lidocaine	_____
[Y] [N] Penicillin/Amoxicillin	[Y] [N] Aspirin/Advil/Tylenol	_____
[Y] [N] Sulfa	[Y] [N] Vicodin	_____
[Y] [N] Clindamycin	[Y] [N] Percocet	

7. Please check the box [Y] YES or [N] NO next to each you currently have or have had previously:

[Y] [N] Arthritis	[Y] [N] Jaw Pain/Jaw Joint Pain	[Y] [N] Asthma
[Y] [N] Artificial Joints Date of surgery _____	[Y] [N] Stroke	[Y] [N] Tobacco Use
[Y] [N] Cancer/Tumor	[Y] [N] Thyroid Problems	[Y] [N] Bronchitis
[Y] [N] Chemotherapy/X-ray/Cobalt	[Y] [N] Tuberculosis (TB)	[Y] [N] Emphysema
[Y] [N] Cold Sores/Fever Blister	[Y] [N] Osteoporosis	[Y] [N] Shortness of Breath
[Y] [N] Diabetes	[Y] [N] Angina Pectoris	[Y] [N] Anemia
[Y] [N] Drug/Alcohol Addiction	[Y] [N] Artificial Heart Valve	[Y] [N] Blood Transfusion
[Y] [N] Epilepsy, Fainting or Dizzy Spells	[Y] [N] Congenital Heart Lesions	[Y] [N] Hemophilia
[Y] [N] Kidney Disease	[Y] [N] Heart Attack	[Y] [N] Leukemia
[Y] [N] Liver Disease	[Y] [N] Heart Disease	[Y] [N] High Blood Pressure
[Y] [N] Hepatitis Type _____	[Y] [N] Heart Murmur/Rheumatic Fever	[Y] [N] Other: _____
[Y] [N] HIV	[Y] [N] Pacemaker	_____

8. Have you been advised to take antibiotics before dental treatment? ..... [Y] YES [N] NO
9. Health History Update: For Office Use Only _____

WOMEN ONLY:

Are you taking birth control pills? [Y] YES [N] NO Are you pregnant? [Y] YES [N] NO month? _____

RESPONSIBLE PARTY CONSENT:

I, the undersigned certify that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I, the undersigned Hereby authorize Silverton Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aid 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 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 services provided in this office for myself or my dependents is mine, due and payable at time of services are rendered. I agree to pay a 1.5% per month finance charge on all accounts 60 days past due. I will give 24 hours notice if I am unable to keep an appointment. Otherwise, I am responsible for any "broken appointment" fee that may be charged.

_____ _____ _____

Responsible Party Signature Relationship Date