

7. Do you have or have you ever had asthma? YES NO NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? YES NO NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? YES NO NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? YES NO NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? YES NO NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? YES NO NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? YES NO NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. YES NO NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

- | | | | | | |
|----------------------------------------------|------------------------------------------------|---------------------------------------|------------------------------------------|--------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> pacemaker | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | medications |
| <input type="checkbox"/> stroke | <input type="checkbox"/> heart murmur | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease | (e.g. Fosamax, Actonel) |
| <input type="checkbox"/> shortness of breath | | <input type="checkbox"/> cancer | <input type="checkbox"/> arthritis | <input type="checkbox"/> drug/alcohol dependency | |
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16. Are there any conditions or diseases not listed above that you have or have had? If so, what? YES NO NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) YES NO NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? YES NO NOT SURE/MAYBE

19. Are you nervous during dental treatment? YES NO NOT SURE/MAYBE

20. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? YES NO NOT SURE/MAYBE

1. I am aware that I will be charged \$ 50 for any missed or cancelled appointments without 48 hours notice.
2. I am aware that if I am excessively late for my scheduled appointment I may not be seen.
3. I am aware that it is my responsibility as a patient to inform the office of any address, contact info or physician changes.
4. I am aware of my insurance plan and my co-pay portion and any change in the insurance will be informed.

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

DENTIST SIGNATURE: _____

DATE: _____

