ONTARIO DENTAL CENTER

Patient Medical History

974 N Mountain Ave
Ontario, CA 91762

Physician: _____ Office Phone: _____ Date of last exam: _____

1. Are you under any medical treatment now? . . . . . Yes or No
2. Have you ever been hospitalized for any surgical operation or serious illness within last 5 yrs? . . Yes or No
   If yes please explain: ……
3. Are you taking any medication (s) including non-prescription medicine? . . . . . Yes or No
   If yes, please list you medication(s):……
4. Do you use tobacco? . . . . . .Yes or No
5. Have you ever taken phen phen? . . . . . Yes or No
6. Do you use controlled substances? . . . . . .Yes or No
7. Are you taking any medication for osteoporosis? . . . . . Yes or No
8. Do you have or had any of the following: (Please Circle yes or no)

High blood Pressure	Y N	Low Blood Pressure	Y N	Chest Pain	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Heart Disease	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Osteoporosis	Y N	Angina	Y N	Mitral Valve Prolapse	Y N
Fainting/Seizures	Y N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anemia	Y N	Radiation Therapy	Y N
Easily Winded	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy/Convulsions	Y N	Cancer	Y N	Recent Weight Lost	Y N
Leukemia	Y N	Arthritis	Y N	Respiratory problems	Y N
Diabetes	Y N	Joint replacement/implant	Y N	Swollen Ankles	Y N
Kidney Disease	Y N	Hepatitis / Jaundice	Y N	Liver Disease	Y N
AIDS or HIV infection	Y N	Stomach troubles/ulcer	Y N	Hay Fever/Allergies	Y N
Thyroid problem	Y N	Sexually transmitted Disease	Y N	Other: _____	

9. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	Y N	Aspirin	Y N	Sedatives	Y N
Penicillin or any other antibiotics	Y N	Any metals	Y N	Latex Rubber /Powder	Y N
Sulfa Drugs	Y N	Iodine	Y N	Other: _____	Y N

10. Women ONLY:
    a) Are you pregnant or think you May be pregnant? Y N
    b) Are you Nursing? Y N
    c) Are you taking any oral Contraceptives? Y N

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including diagnosis and the records to any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to the dental x-rays, diagnostic procedures and treatment by the dentist necessary for proper dental care.

_____ _____

Signature of Patient / Parent / Guardian and Date — Dentist's Signature and Date

FOR FUTURE VISITS/APPOINTMENTS ONLY- RECALL REVIEW UPDATE & COMMENTS:

Any change(s) in health history or Medical condition? *If Yes, Please explain:*

	Patient's signature	Date	Dentist Signature
❑*Yes* ❑*No*			
❑*Yes* ❑*No*			
❑*Yes* ❑*No*			