LADERA RANCH
DENTISTRY & ORTHODONTICS

NAME:

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Mark yes or no by placing an X

	Yes	No
1. Are you under medical treatment right now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious injury?	☐	☐
3. Are you taking any medication(s) Including non-prescription medication? If yes, What medications are you taking? _____	☐	☐
4. Have you ever been prescribed antibiotics Prior to receiving dental treatment?	☐	☐
4a. Have you ever taken phen –phen?	☐	☐

5. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetic (eg. Novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Codeine	☐	☐
Latex	☐	☐
Other	☐	☐

6. Women Only:	Yes	No
a) Are you pregnant or think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

7. Do you have or have had any of the following?

Mark yes or no by placing an X

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Coumadin Therapy	☐	☐
High Blood Pressure	☐	☐
Prolonged Bleeding	☐	☐
Anemia	☐	☐
Stroke	☐	☐
Joint replacement	☐	☐

	Yes	No
Rheumatic Fever	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Hay Fever/ Allergies	☐	☐
Tuberculosis	☐	☐
Fainting/ Seizures	☐	☐
Epilepsy/ Convulsions	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Cancer	☐	☐
Arthritis	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Down Syndrome	☐	☐
Alzheimer's	☐	☐
Aids or HIV Infection	☐	☐
STD	☐	☐
Bisphosphonate	☐	☐
Other	☐	☐

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 authorized the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child 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 no other dentist nor Ladera Ranch Dentistry & Orthodontics is responsible for my dental treatment. I hereby give my consent to have necessary treatment recommendations performed.

Signature of patient or parent (if minor) **X**_____

Doctor Signature:_____

Comments:_____

_____

Date: __/__/___