Medical History and Authorization

Patient Name: Birth Date: Date Created:

Are you under a physician's care now for any illness or condition?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation in the last 2 years?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Are you required to pre-medicate before dental treatment?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other allergies not listed? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Herpes ◯ Yes ◯ No	Angina ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No
Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Any anxiety or fear of dental work? ◯ Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I also authorize Castro Valley Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize and request my insurance company to pay directly to Dr. Young insurance benifits otherwise payable to me. I UNDERSTAND THAT I AM FULLY RESPONISBLE FOR THE ENTIRE AMOUNT OF THE SERVICE, WHETHER OR NOT I HAVE INSURANCE, THAT IS NOT COVERED OR PAYED FOR BY ANY THIRD PARTY.

Signature of Patient, Parent or Guardian:

X Date:_____