NAISBITT

MEDICAL HISTORY

Name:_____

Are you currently being treated by a physician? YES NO Physicians Name:_____ Number:_____

Reason:_____

Please specify any medications you are currently taking:_____

_____

Have you had any serious illness or operations? If yes, please describe:_____

_____

Do you have any allergies/sensitivities to medications or latex? YES NO If yes, please list:_____

(Women) Are you pregnant? YES NO Nursing? YES NO Taking Birth Control YES NO

Check if you have or have ever had any of the following:

___Anemia	___Hepatitis	___Arthritis, Rheumatism	___Cough, Persistent
___High Blood Pressure	___Shortness of Breath	___Artificial Heart Valve	___HIV/AIDS
___Artificial Joints	___Diabetes	___Jaw Pain	___Stroke
___Asthma	___Tuberculosis	___Epilepsy	___Kidney Disease
__Cold Sores, Fever Blisters	___Liver Disease	___Prolong Bleeding	___Cortisone
___Thyroid Problems	___Blood Disease	___Mitral Valve Prolapse	___Tobacco Habit
___Cancer	___Headaches, Fainting	___Pacemaker	___Tonsillitis
___Heart Murmur	___Heart Problems	___Respiratory Disease	___Ulcer
___Circulatory Problems	___Hemophilia	___Rheumatic Fever	___Penicillin Allergy

How long ago did you last see a dentist?_____ Are you allergic to local anesthetic? YES NO

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

Signature:_____ Date:_____ Reviewed By:_____ Date:_____

___There are no changes in my medical history

Medical changes are:_____

Signature:_____ Date:_____ Reviewed By:_____ Date:_____

___There are no changes in my medical history

Medical changes are:_____

Signature:_____ Date:_____ Reviewed By:_____ Date:_____