Have you ever been: Hospitalized Operated on

Treated for any other conditions not on this form? _____

Are you currently taking any of the following?

Steroids Tranquilizers Aspirin Blood Pressure Medication Thyroid Medicine

List All Medications you are currently taking: _____

I understand that this medical history is a legal document and that I have answered all of the above questions to the best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I have made in the completion of this form. I hereby authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balances. I authorize the Doctor to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also assign all insurance benefits directly to the Doctor.

Signature of Patient or Legal Guardian X _____ Date _____