== *Health History* ==

Physician name _____ City _____ Phone _____

List any drugs or medications patient is currently taking _____

_____

List any allergies or sensitivities

_____

Does patient have to take medication prior to dental work? _____

Women: Are you or could you be pregnant? _____

Please indicate if patient has or has had any of the following:

_____ Heart disease
_____ Heart attack
_____ Heart murmur
_____ Mitral valve prolapse
_____ Artificial joints or heart valves
_____ Rheumatic fever or rheumatic heart disease
_____ Chest pain or angina pectoris
_____ High/low blood pressure
_____ Blood disorder
_____ Hepatitis or other liver disease
_____ Asthma or other lung disease
_____ Kidney disease
_____ Diabetes
_____ Cancer
_____ Stroke
_____ Glaucoma
_____ Fainting spells or seizures
_____ Nervous or emotional disorders
_____ Positive HIV test
_____ Sexually transmitted diseases
_____ Herpes

Are there any other conditions, diseases, or problems we should be aware of?

_____

Emergency Contact (other than parent) _____ Phone _____

I will inform Dr. Stafford of any changes to my medical history.

I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is dental or medical in nature. I additionally authorize payment directly to Gary D. Stafford, D.D.S. of the insurance benefits otherwise payable to me. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
To the best of my knowledge, every question has been answered truthfully and completely.

Date _____ Signature_____