CONFIDENTIAL MEDICAL QUESTIONNAIRE

Correct answers to the following questions will allow Dr.Clark to treat you so there <u>WILL NOT</u> be an emergency. However, if an emergency situation does arise this information will help insure proper treatment. Your answers are for our records only and will be considered confidential.

1. Are you having pain or discomfort at this time?..... ☐ Yes ☐ No
2. Do you feel very nervous about having dental treatment?..... ☐ Yes ☐ No
3. Have you ever had a bad experience in a dental office?..... ☐ Yes ☐ No
4. Have you been hospitalized in the past two years?..... ☐ Yes ☐ No
5. Have you been under the care of a medical doctor during the past two years?..... ☐ Yes ☐ No

Physician's Name _____

Address _____ Phone# ( ) _____

7. Have you taken any medicine or drugs during the past two years?..... ☐ Yes ☐ No
8. Are you now taking any medication, drugs or pills?..... ☐ Yes ☐ No

If "Yes" please list those drugs: _____

_____

9. Are you aware of being allergic to any of the following?

☐	Aspirin	☐	Erythromycin	☐	Novocaine/Xylocaine	☐	Scopolamine
☐	Darvon	☐	Local Anesthetic	☐	Other Antibiotics	☐	Sleeping Pills
☐	Demerol	☐	Nembutal/Seconal	☐	Penicillin	☐	Tetracycline
☐	Codeine	☐	Nitrous Oxide	☐	Percodan	☐	Valium

10. Are you aware of being allergic to any other medication or substance?..... ☐ Yes ☐ No
11. Check any of the following which you have had or have at present:

☐	A.I.D.S.	☐	Cough	☐	Heart Murmur	☐	Rheumatic Fever
☐	Allergies or Hives	☐	Diabetes	☐	Heart Pacemaker	☐	Rheumatism
☐	Anemia	☐	Drug Addiction	☐	Heart Surgery	☐	Scarlet Fever
☐	Angina Pectoris	☐	Emphysema	☐	Hemophilia	☐	Sickle Cell Disease
☐	Artificial Joints	☐	Epilepsy or Seizures	☐	HepatitisA/infectious	☐	Sinus Trouble
☐	Arthritis	☐	Fainting/Dizzy spells	☐	HepatitisB/serum	☐	Stroke
☐	Asthma	☐	Fever Blisters	☐	High Blood Pressure	☐	Syphilis
☐	Blood Transfusion	☐	Glaucoma	☐	Kidney Trouble	☐	Thyroid Disease
☐	Bruise Easily	☐	Hay Fever	☐	Leukemia	☐	Tuberculosis (TB)
☐	Chemotherapy	☐	Heart Attack	☐	Liver Disease	☐	Ulcers
☐	Cold Sores	☐	Heart Disease	☐	Nervousness	☐	Venereal Disease
☐	Cortisone Medicine	☐	Heart Failure	☐	Pain in Jaw Joints	☐	X-ray/Cobalt Trxt.
☐	Cosmetic Surgery	☐	Heart Lesions	☐	Psychiatric Trxt.	☐	Yellow Jaundice

12. Do you ever have shortness of breath or chest pains?..... ☐ Yes ☐ No
13. Do your ankles swell during the day?..... ☐ Yes ☐ No
14. Do you use more than 2 pillows to sleep?..... ☐ Yes ☐ No
15. Have you lost or gained more than 10 pounds in the past year?..... ☐ Yes ☐ No
16. Do you ever wake up from sleeping with shortness of breath?..... ☐ Yes ☐ No
17. Are you on a special diet?..... ☐ Yes ☐ No
18. Has your medical doctor ever said you have a cancer or tumor?..... ☐ Yes ☐ No
19. Do you have any disease, condition, or problem not listed?..... ☐ Yes ☐ No
20. **Women Only** Are you Pregnant or think you may be?..... ☐ Yes ☐ No
21. **Women Only** Are you taking birth control pills?..... ☐ Yes ☐ No

Consent: *The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Clark to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Clark to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Dr. Clark choose and employ such assistance as he deems fit. I also understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 45 days. In the event of default I (We) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.*

Patient _____ Date _____ Witness _____

Parent of Responsible Party _____ Relationship to Patient _____