

STEWART DENTAL *the Smile Shoppe!*

Medical History

1. Name of Medical Doctor: _____ Phone Number (Medical Dr.): _____

2. Are you taking any medications, or drugs? Yes No

If yes, please list: _____

3. Do you have any drug allergies? Yes No

If yes, please list: _____

4. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item:

Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease or Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	A.I.D.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriosclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cosmetic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Developmentally Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Do you or have you ever had any type of cancer? Yes No

If yes, please list: _____

6. Do you or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

FOR WOMEN ONLY: Are you pregnant? Yes No If yes, what month? _____

Are you nursing? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

1. The undersigned hereby authorize doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all 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 unless other arrangements have been made. I hereby authorize my insurance benefits to be paid directly to Dr. Stewart. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge (18%APR) may be added to my account.

Responsible Party

Date

Print Patient Name

Dr. Signature

Print Patient's Name: _____