Patient Health History

Patient:_____

Name of Primary Physician	Date of Last Physicial
Physician's Address	Are you under the care of a Dr. now? ------Yes No If so, what for? _____

Have you been hospitalized or had any serious illness during the past 5 years ----------Yes No

If so, for what?_____

Have there been any changes in your health during the last year ----------Yes No

If so, for what?_____

What is your blood pressure? _____ / _____

Have you ever had any of the following: (Please Circle)

Y	N	Anemia	Y	N	Heart Murmur	Y	N	Stomach Ulcers
Y	N	AIDS (or ARC)	Y	N	Mitral Valve Prolapse	Y	N	Rheumatism / Arthritis
Y	N	Venereal Disease	Y	N	Abnormal Heart Condition	Y	N	Liver Disease
Y	N	Diabetes	Y	N	Abnormal Bleeding	Y	N	Pacemaker
Y	N	Epilepsy	Y	N	Prosthetic Valves	Y	N	Asthma
Y	N	Hepatitis	Y	N	Prosthetic Replacements	Y	N	Radiation Therapy
Y	N	Rheumatic Fever	Y	N	Abnormal Blood Pressure	Y	N	Blood Transfusion
Y	N	Tuberculosis	Y	N	Kidney Problems	Y	N	Stroke

Do you have allergies to: (Please Circle)

Latex, Penicillin, Local Anesthetics, Sulfa Drugs, Barbiturates, Tetracycline, Sedatives, Sleeping Pills, Erythromycin, Nitrous Oxide, Aspirin, Iodine, Codeine, Narcotics, Or Any Other Medications or Drugs.

If so, please explain: _____

Are you now taking any drugs or medications? _____ If yes, please list:

Taking_____ For _____ Taking_____ For _____

Taking_____ For _____ Taking_____ For _____

Taking_____ For _____ Taking_____ For _____

Are you using OR have you ever used biophosphonates: (Please Circle) ie: Fosamax, Actonel, or Boniva?

Do you have any diseases or conditions not mentioned above? ----------Yes No

If so, please explain: _____

Women: Are you now or do you expect to be pregnant during the course of dental care? --------Yes No

If so, Due Date: _____

Consent: I authorize Dr. Chan and staff to perform diagnostic and operative treatment, medication, and therapy that may be indicated and mutually agreed upon by me. I understand that responsibility of payment for dental services provided in this office is mine, due and payable at the time services are rendered. I authorize payment directly to John Chan, a Professional Corporation, of dental benefits otherwise payable to me and accept that my insurance provider may deny my claims. A service fee of 2% monthly (24% annually) will be charged on balances over 90 days. I understand that the Notice of Privacy Practices and Dental Materials Fact Sheet have been provided to me and are also available to me upon request. I agree to pay a $50 (fifty dollars) fee for each missed appointment, when I do not provide 48 (forty-eight) hours notice.

Patient/Parent Signature: _____Date: _____