

From: Christine [cem1967@ptd.net]
Sent: Friday, December 05, 2008 12:48 PM
To: Mubina Gangji
Subject: Medical information Form.doc

ADULT / CHILD
PATIENT MEDICAL INFORMATION

	Yes	No		Yes	No
Joint Replacement	_____	_____	Heart Trouble	_____	_____
Heart Murmur	_____	_____	High Blood Pressure	_____	_____
Valve Replacement	_____	_____	Low Blood Pressure	_____	_____
Mitral-Valve Prolapse	_____	_____	Nervous Disorders	_____	_____
Aids or HIV test (pos)	_____	_____	Epilepsy	_____	_____
Hepatitis	_____	_____	Diabetes	_____	_____
Rheumatic Fever	_____	_____	Stroke	_____	_____
Venereal Disease	_____	_____	Cancer	_____	_____
Bronchitis	_____	_____	Hay Fever	_____	_____
Asthma	_____	_____	Anemia	_____	_____
Tuberculosis	_____	_____	Radiation Therapy	_____	_____
Kidney Disease	_____	_____	Leukemia	_____	_____
Thyroid Disease	_____	_____	Blood Disease	_____	_____

Liver Disease _____

******Are there any other conditions that may be important to your care?** Yes No

Is the Patient under the care of a Physician at this time or within the last 2 years?
 If so, for what? _____

Has the patient been hospitalized within the past 2 years?
 If so, for what? _____

Have you ever had an Allergic Reaction to any Medication (itching, swelling, hives etc.)
 If so, what medications? _____

Are you currently taking any medications?
 If so, please list: _____

Permission is hereby granted to perform any necessary dental work and authorize my insurance company to pay the dentist or dental group all insurance benefits. I also understand that (regardless of my insurance status), I am responsible for the balance on this account for any and all services rendered to me or my dependents. I certify that this information is true and correct to the best of my knowledge. I will notify of any changes in my health or the information above.

Signature _____ date _____
