MEDICAL HISTORY
Garr Dental Center

1. Are you having pain or discomfort at this time? ___Yes___No
2. Are you having sensitivity to… ___Hot ___Cold ___Sweet
3. Do you have pain or discomfort when chewing? ___Yes___No
4. Do you have bleeding, swollen or irritated gums? ___Yes___No
5. Do you have bad breath or a bad taste in your mouth? ___Yes___No
6. Are you interested in whitening your teeth? ___Yes___No
7. Do you feel nervous about having dental treatment? ___Yes___No
8. Have you ever had a bad experience in a dental office? ___Yes___No
9. Have you been hospitalized in the past two years? ___Yes___No
10. Are there any specific concerns Dr. Garr can address today? ___Yes___No
11. Have you been under the care of a medical doctor during the past two years?___Yes___No

Physician's Name & Phone Number:____

12. Are you now taking any medications, drugs, or pills? ___Yes___No List ________________________

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13. Are you now taking any vitamins, supplements, or herbal therapy? ___Yes___No List ________________________
14. Are you allergic to any medications? _____Yes _____No If yes, please list ______________________________________

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15. Check any of the following which you have had, or have at the present time:

__AIDS	__HIV positive	__Respiratory Problems	__Rheumatic Fever	__Allergies/Hives	__Diabetes
__Heart Surgery	__Rheumatism	__Glaucoma	__Low Blood Pressure	__Hemophilia	__Scarlet Fever
__Angina Pectoris	__Hepatitis A	__Emphysema	__High Blood Pressure	__Artificial Joints	__Epilepsy
__Arthritis	__Hepatitis B	__Cancer	__Fainting / Dizzy Spells	__Seizures	__Sinus / Hay Fever
__Stroke	__Hepatitis C	__Leukemia	__Blood Transfusion	__Bruise Easily	__Anemia
__Liver Disease	__Heart Disease	__Chemotherapy	__Mitral Valve Prolapse	__Syphilis	__Thyroid
__Cold Sores	__Heart Failure	__Radiation	__Cortisone Medicine	__Tuberculosis	__Ulcers
__Heart Murmur	__Heart Attack	__Nervousness	__Venereal Disease	__Psychiatric Trxt	__Drug Addiction
__Yellow Jaundice	__Pacemaker	__Pain in Jaw Joints	__Phen-Phen/Redux	__Head Aches	__Other

16. Do you have any disease, condition, or problem not listed? ___Yes___No

    If yes, please list____

17. **Women only** Are you pregnant or think you may be? ___Yes___No
18. **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 to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient)___________________________________ and further authorize consent that the doctor choose and employ such assistance as s/he deems fit. I also understand that responsibility for payment for dental services provides in this office for my dependents or myself is mine, due and payable at the time services are rendered. 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 my be required, to effect collection of this note.*

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Patient/Guardian Signature Date Relationship to patient