NAME: _____
CHART#: _____

ARCADIA DENTAL GROUP

UPDATE GENERAL HEALTH INFORMATION

1. ARE YOU UNDER A DOCTOR'S CARE AT THIS TIME? YES NO If yes, please specify _____

_____

_____ .

- **Physician's name and phone number**: _____

  _____

2. ARE YOU ALLERGIC TO **PENICILLIN**, **CODEINE**, **LOCAL ANESTHETICS**, **TRANQUILIZERS** OR **ANY OTHER DRUGS OR MEDICINE**? YES NO If yes, please specify _____
3. ARE YOU TAKING ANY MEDICATION AT THIS TIME? YES NO If yes, please specify _____

   _____.
4. (WOMEN) ARE YOU PREGNANT AT THIS TIME? YES NO If yes, please specify how many months _____.
5. DO YOU NOW HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING :

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/ARC	☐	☐	DIABETES	☐	☐	HEART MURMUR	☐	☐	LUNG DISEASE	☐	☐
ALLERGIES	☐	☐	DIZZY SPELLS	☐	☐	HEART PROBLEMS	☐	☐	PHEN PHEN	☐	☐
ANEMIA	☐	☐	EMPHYSEMA	☐	☐	HEPATITIS	☐	☐	PACEMAKER	☐	☐
ANGINA	☐	☐	EPILEPSY	☐	☐	HIGH BLOOD PRESS.	☐	☐	RHEUMATIC FEVER	☐	☐
ARTHRITIS	☐	☐	FAINTING	☐	☐	JAUNDICE	☐	☐	SNORING	☐	☐
ASTHMA	☐	☐	FEVER BLISTERS	☐	☐	KIDNEY DISEASE	☐	☐	STROKE	☐	☐
BIOPHOSPHONATES			GLAUCOMA	☐	☐	LIVER PROBLEMS	☐	☐	THYROID PROBLEMS	☐	☐
(Boniva,Fosamax,Reclast)	☐	☐	HEART ATTACK	☐	☐	LATEX ALLERGY	☐	☐	TUBERCULOSIS	☐	☐
PROSTHETIC			HEART BYPASS	☐	☐	LOW BLOOD PRESS.	☐	☐	VENEREAL DISEASE	☐	☐
HIP REPLACEMENT	☐	☐	CANCER	☐	☐						

6. ARE THERE ANY OTHER CONDITIONS WE SHOULD BE AWARE OF? YES NO _____

   _____.

I HAVE REVIEWED HEALTH HISTORY WITH PATIENT:

_____
Signature of Doctor

- I have filled out this health questionnaire completely and have advised you of all medical problems of which I am aware. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist nor Arcadia Dental Group is responsible for my dental treatment.

_____ _____

Signature of Patient or Responsible Party Date / Relationship