DAG ZAPATERO, D.D.S.
FELLOW ACADEMY OF GENERAL DENTISTRY

MEDICAL HISTORY

Name: _____

General Health (please circle): Excellent Good Fair Poor Physician: _____

Physician's address: _____ Phone: _____

Are you allergic to any medication? Yes No If yes, list the medication: _____

Are you allergic to Latex? Yes No Are you taking any medications now? Yes No

If yes, please list the medications and medical condition for which they are being taken: _____

_____

For our female patients: Are you pregnant? Yes No Number of months: ___ Nursing? Yes No Taking birth control? Yes No

Have you ever had any of the following? Please circle any condition that applies to you:

Heart Disease	Anemia	Mitral Valve Prolapse	Hepatitis
Rheumatic Fever	Arthritis	Heart Murmur	Glaucoma
Night Sweats	Lymph Node Enlargement (swollen glands)	Allergies	Stroke
High Blood Pressure		Jaundice	Fainting Spells
Ulcers	Migraine Headaches	Drastic Weight Loss	Cancer
Tuberculosis or Lung Cancer	HIV/AIDS	Asthma	Congenital Heart Lesions
Diabetes	Prolonged Bleeding	Hay Fever	
Epilepsy	Excessive Urination and/or Thirst	Sinus Trouble	

Do you smoke, use tobacco, alcohol or drugs? Yes No If yes, list the type and how often:

_____

If you have circled any of the above conditions, please explain or if you have or have had any disease, condition or problem not listed above please explain:

_____

DENTAL HISTORY

1. Are you presently having any dental pain? _____

2. Are you happy with the way your teeth look? _____

3. What do you expect from your visit today? _____

4. When was your last dental visit? _____ 5. When was your last cleaning? _____

6. Please add anything you feel is important for the doctor to know. _____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matter related to this form. I have answered all questions to the best of my knowledge. Should further medical information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you.

Patient Signature: _____ Date: _____

If patient is UNDER 18 YEARS OLD, parent or legal guardian MUST sign above. If you were assisted with this form, please enter the name of the person who assisted you: _____ Relationship to Patient: _____