Tad A. Erickson D.D.S. Inc. **Date** ____________________

Patient's Name ______________________________ Age ________ Birthdate ________________________

Address (home) ______________________________ City ________________ Zip ______________

Phone ______________________________________ Marital Status ______________________________

Name of spouse ____

If a child, parent's names ____

Employer ___________________________________ Occupation ________________________________

Address (business) ___________________________ City ________________ Zip ______________

Phone ______________________________________ Social security number ________________________

Spouse employed by __________________________ Occupation ________________________________

Address (business) ___________________________ City ________________ Zip ______________

Phone ______________________________________ Social security number ________________________

Referred to this office by ____

MEDICAL HISTORY **Your Physician's Name** ______________________________ **Tel:#** ________________________

#	Question		
1.	Are you having pain or discomfort at this time?	YES	NO
2.	Do you feel nervous about having dental treatment?	YES	NO
3.	Have you ever had a bad experience in a dentist's office?	YES	NO
4.	Have you been a patient in the hospital during the past two years?	YES	NO
5.	Have you been under the care of a medical doctor during the past two years?	YES	NO
6.	Have you taken any medicine or drugs during the past two years?	YES	NO
7.	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?	YES	NO
8.	Have you ever had any excessive bleeding requiring special treatment?	YES	NO

9. Check any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS, ARC
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congential Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Veneral Disease
Heart Pacemaker	X-ray or Cobalt Treatment	(Syphillis, Gonorrhea)
Heart Surgery	Chemotherapy	Cold Sores
Artificial Joint	(Cancer, Leukemia)	Genital Herpes
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Arthritis	Epilepsy or Seizures	Bruise Easily

#	Question		
10.	When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?	YES	NO
11.	Do your ankles swell during the day?	YES	NO
12.	Do you use more than 2 pillows to sleep?	YES	NO
13.	Have you lost or gained more than 10 pounds in the past year?	YES	NO
14.	Do you ever wake up from sleep short of breath?	YES	NO
15.	Are you on a special diet?	YES	NO
16.	Has your medical doctor ever said you have cancer or a tumor?	YES	NO
17.	Do you have any disease, condition, or problem not listed?	YES	NO
18.	WOMEN: Are you pregnant now?	YES	NO
	Are you practicing birth control?	YES	NO
	Do you anticipate becoming pregnant?	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

______________ ______________________ ______________________________

Date Dentist Signature Signature of Patient, Parent or Guardian

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. I hereby authorize Tad A. Erickson, D.D.S., to perform any and all dental treatment and to use such methods, drugs and agents as seen advisable. This consent and authorization shall remain in effect until cancelled.
   Signature ______________________________ Relationship ____________________ Date __________________
2. I hereby assume any and all financial responsibility for treatment and hereby assign payment of all dental care insurance benefits to Tad A. Erickson, D.D.S., and assume responsibility for fees not covered by my group insurance.
   Signature ____ Date __________________
3. If divorced, who will be financially responsible for payment?
4. Methonds of payment: (Payment is expected for the service rendered at the first visit, financial arrangements for subsequent work may be made in any of the following ways.) a. Payment for each visit b. Dental insruance, with co-payment
   Name of person insured ____
   Name of insurance ______________________________ Group or Policy No. ____________________