ELIZABETH KILPATRICK-FOX, D.M.D.

MEDICAL INFORMATION

1. Are you having pain or discomfort at this time? ..... ❑YES ❑NO

2. Have you been a patient in the hospital during the past two years? ..... ❑YES ❑NO

3. Have you been under the care of a medical doctor during the past two years? ..... ❑YES ❑NO

Physician's Name _____ Phone No. _____

Address _____

4. Have you taken any medication or drugs during the past two years? ..... ❑YES ❑NO

5. Are you now taking any medication or drugs? ..... ❑YES ❑NO

If yes, please list: _____

6. Are you sensitive or allergice to any medication or anesthetics? ..... ❑YES ❑NO

If yes, please list: _____

7. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item.

Heart Failure ..... ❑YES ❑NO	Artificial Joints (hip, knee, etc.) ..... ❑YES ❑NO	Hepatitis B (serum) ..... ❑YES ❑NO
Heart Disease or Attack ..... ❑YES ❑NO	Kidney Trouble ..... ❑YES ❑NO	Venereal Disease ..... ❑YES ❑NO
Angina Pectoris ..... ❑YES ❑NO	Ulcers ..... ❑YES ❑NO	A.I.D.S. ..... ❑YES ❑NO
Congenital Heart Disease ..... ❑YES ❑NO	Diabetes ..... ❑YES ❑NO	H.I.V. Positive ..... ❑YES ❑NO
Heart Murmur ..... ❑YES ❑NO	Thyroid Problems ..... ❑YES ❑NO	Cold Sores/Fever Blisters ..... ❑YES ❑NO
High Blood Pressure ..... ❑YES ❑NO	Glaucoma ..... ❑YES ❑NO	Blood Transfusion ..... ❑YES ❑NO
Arterioscierosis ..... ❑YES ❑NO	Cancer ..... ❑YES ❑NO	Hemophilia ..... ❑YES ❑NO
Mitral Valve Prolapse ..... ❑YES ❑NO	Emphysema ..... ❑YES ❑NO	Anemia ..... ❑YES ❑NO
Artificial Heart Valve ..... ❑YES ❑NO	Chronic Cough ..... ❑YES ❑NO	Sickle Cell Disease ..... ❑YES ❑NO
Heart Pacemaker ..... ❑YES ❑NO	Tuberculosis ..... ❑YES ❑NO	Bruise Easily ..... ❑YES ❑NO
Heart Surgery ..... ❑YES ❑NO	Asthma ..... ❑YES ❑NO	Liver Disease ..... ❑YES ❑NO
Rheumatic Fever ..... ❑YES ❑NO	Hay Fever ..... ❑YES ❑NO	Yellow Jaundice ..... ❑YES ❑NO
Arthritis ..... ❑YES ❑NO	Allergies or Hive ..... ❑YES ❑NO	Epilepsy or Seizures ..... ❑YES ❑NO
Rheumatism ..... ❑YES ❑NO	Sinus Trouble ..... ❑YES ❑NO	Fainting or Dizzy Spells ..... ❑YES ❑NO
Cortisone Medicine ..... ❑YES ❑NO	Radiation Therapy ..... ❑YES ❑NO	Nervousness ..... ❑YES ❑NO
Drug Addiction ..... ❑YES ❑NO	Chemotherapy ..... ❑YES ❑NO	Tumors ..... ❑YES ❑NO
Stroke ..... ❑YES ❑NO	Hepatitis A (infectious) ..... ❑YES ❑NO	Developmentally Disabled ..... ❑YES ❑NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... ❑YES ❑NO

9. Do your ankles swell during the day? ..... ❑YES ❑NO

10. Do you use more than two pillows to sleep? ..... ❑YES ❑NO

11. Have you lost or gained more than 10 pounds in the past year? ..... ❑YES ❑NO

12. Do you ever wake up from sleep and feel short of breath? ..... ❑YES ❑NO

13. Are you on a special diet? ..... ❑YES ❑NO

14. Do you have or have you had any disease, condition, or problem not listed? ..... ❑YES ❑NO

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ❑YES What month? _____ ❑NO Are you nursing? ❑YES ❑NO Are you taking birth control pills? ❑YES ❑NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account.

4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____