HEALTH INFORMATION

Do you have any of the following conditions? Please circle those that apply:

AIDS/HIV Positive
Hepatitis A, B or C
Arthritis/Gout
Shingles
Breathing Problems/Asthma
Bruise Easily
Hay Fever/Allergies
Pain in Jaw Joints
Lupus
Chest Pain
Thyroid Problem
Diabetes
Easily Winded
Epilepsy or Seizures

Artificial Joint
Kidney Problems
Frequent Headaches
Cancer
Heart Attack/Heart Troubles
Pacemaker
Fibromyalgia/Chronic Fatigue Syndrome
Sleep Apnea
Smoker/Chewing Tobacco
Rheumatic Fever
Low/ High Cholesterol
Blood Disorder
Liver Disease
Glaucoma

Osteoporosis
Depression
Emphysema/COPD
Drug Addiction
Low/ High Blood Pressure
Artificial Heart Valve
Irregular Heartbeat
Stomach/Intestinal Disease
Stroke
Chemotherapy
Tuberculosis
ADD/ADHD
Mental Health Conditions

How much do you smoke per day? _____ Do you use recreational drugs? _____

Do you have any conditions or illnesses not listed above? _____ If so, please list them below.

Please list all prescriptions and any over-the-counter medications you are currently taking

Circle any of the following you may be allergic to:

ASPIRIN CODEINE LATEX ANY METALS LOCAL ANESTHETICS ACRYLIC
ERYTHROMYCIN PENICILLIN SULFA ANY NARCOTICS OTHER?

PHYSICIAN'S NAME: PHONE #: LAST EXAM:

FOR WOMEN ONLY:

1. Are you pregnant or think you may be pregnant? YES or NO
2. Are you nursing? YES or NO
3. Are you taking Oral Contraceptives? YES or NO

I certify that I have read and understand the above information to the best of my knowledge. The about questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE: RELATIONSHIP: DATE:

RAYMOND DENTAL GROUP
FAMILY DENTISTRY & SEDATION CARE

Your Comfort.
Your Smile.
Our Priority.

4332 Cleveland Massillon Rd. | Norton, OH 44203
330.825.4446 PH | 330.825.4447 FAX
RaymondDentalGroup.com