HEALTH HISTORY

PLEASE COMPLETE, SIGN AND DATE THE BOTTOM OF THIS FORM

PATIENT NAME:				DATE:
	LAST	FIRST	M.I	

Contact Person in case of emergency? Phone No.

PHYSICIAN Address Phone No.

CURRENT MEDICATIONS AND DOSAGES (LIST)	ALLERGIES	HOSPITALIZATIONS/OPERATIONS		
Include any Herbal or "Over the Counter" medications		HOSPITAL	Date	Reason

DATE AND RESULTS OF LAST PHYSICAL EXAM

ARE YOU UNDER PHYSICIAN'S CARE? YES/ NO REASON:

ARE YOU UNDER THE CARE OF A SPECIALIST? YES/ NO REASON:

PLEASE PLACE AN "X' IN THE LEFT BOX IF YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:

	ABNORMAL BLOOD PRESSURE		ASTHMA		EMOTIONAL PROBLEMS	**FAMILY HISTORY OF:**	
	HEART MURMUR		LUNG DISEASE		THYROID PROBLEMS		CANCER
	HEART ATTACK		GLAUCOMA		OTHER GLAND PROBLEMS		HEART DISEASE
	RHEUMATIC FEVER		EYE PROBLEMS		STEROID TREATMENT		HIGH BLOOD PRESSURE
	OTHER HEART DISEASE		HEAD INJURY		SEIZURES-CONVULSIONS		DIABETES
	CHEST PAINS		FREQUENT NOSE BLEEDS		STROKE		TYROID DISEASE
	DIABETES		SINUS PROBLEMS		FAINTING		KIDNEY DISEASE
	OTHER BLOOD VESSEL DISEASE		HEADACHES		ARTHRITIS		LUNG DISEASE
	FREQUENT SORE THROAT		OTHER NOSE PROBLEMS		BROKEN BONES	**WOMAN:**	
	OTHER THROAT PROBLEMS		ANEMIA		AIDS		PREGNANT?
	STOMACH ULCERS		BLEEDING PROBLEMS		HIV POSITIVE		# OF MONTHS
	STOMACH DISORDERS		OTHER BLOOD PROBLEMS		TUMOR		MISCARRIAGE
	INTESTINAL DISORDERS		TUBERCULOSIS		CANCER		POSSIBLY PREGNANT?
	KIDNEY DISEASE		VENEREAL DISEASE(VD)		RADIATION TREATMENT		
	JAUNDICE		SKIN RASH		PACEMAKER		TAKING BIRTH CONTROL PILLS?
	HEPATITIS		SKIN PROBLEMS		ARTIFICAL JOINTS		
	LIVER DISEASE		SCARLET FEVER		ARTIFICAL IMPLANTS		

SERIOUS ILLNESSES (LIST)

PLEASE LIST ANY OTHER HEALTH PROBLEMS OR ADDITIONAL INFORMATION

HABITS:

SMOKING (PKS PER DAY)_________ ALCOHOL (DRINKS PER DAY)________ RECREATIONAL DRUGS Y / N CHEW TOBACCO Y / N

UPDATES: OFFICE USE ONLY

DATE	REVISION	SIGNATURE	DATE	REVISION	SIGNATURE	DATE	REVISION	SIGNATURE

THERE IS A 1.5% INTEREST CHARGE WITH A MIMIMUM OF$0.75 ON ACCOUNTS OVER 30 DAYS. $15.OO IS CHARGED TO ACCOUNTS OVEI

I AUTHORIZE DR.JAY C. TOTH AND HIS STAFF TO PERFORM ALL NECESSARY DENTAL PROCEDURES AS MUTUALLY DISCUSSED.

I UNDERSTAND THAT I AM FINANCALLY RESPONSIBLE FOR ALL SERVICES RENDERED REGARDLESS OF MY INSURANCE COVERAGE.

PATIENT SIGNATURE(GUARDIAN)____DATE: _____________