

ARE YOU ALLERGIC TO: (CHECK IF 'YES')

Penicillin Aspirin Anesthetic (Freezing) Codeine Other: _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (PLEASE ATTACH SHEET FOR MORE SPACE)

MEDICATION	REASON

MEDICATION	REASON

HAVE YOU EVER HAD OR EXPERIENCED.... (CHECK IF 'YES' AND SPECIFY THE APPROXIMATE YEAR)

YES	CONDITION	NOTES
	Diabetes	
	Thyroid Problems	
	Glandular Disorders	
	Heart Disease	
	Blood Pressure Problems	
	Angina (chest pain)	
	Heart Surgery	
	Pace-Maker	
	Heart Valve Replacement	
	Circulation Problems	
	Bleeding Problems	
	Heart Murmur	
	Lung Disease	
	Asthma	
	Sinus Problems	
	Snoring / Sleep Apnea	
	CPAP Intolerant	
	Arthritis	
	Joint Replacement	
	Osteoporosis	
	Autoimmune Disorders	
	Pregnancy (current)	

YES	CONDITION	NOTES
	Liver Problems	
	Alcohol Abuse	
	Hepatitis	
	Kidney Problems	
	Drug Abuse	
	Cancer / Cancer Treatment	
	Smoking (past? / present?)	
	Ulcers	
	Psychiatric Care	
	Epilepsy / Convulsions	
	AIDS / HIV / STD	
	Child / Spousal Abuse	
	Family / Domestic Violence	
	Head / Face / Neck Injury	
	Concussions	
	Jaw Fractures	
	Car Accident	
	Eye Surgery	
	Alzheimer's	
	Anorexia / Bulimia	
	Chicken Pox	

CONSENT

1. Consultation with your medical doctor may be necessary to assure safe dental treatment.
2. Some dental insurance companies request information such as copies of X-rays or specific dental information to determine coverage.
3. The patient (guardian) is responsible for all costs and should be reimbursed by their insurance carriers according to the contract of their dental plan.

I hereby allow Dr. Yim to obtain/release information, as noted above, and as required:

Signature (or parent for children under 18 years): _____ Date: _____