Medical History

Please circle the following which apply:

Rheumatic Fever	**Yes** or **No**	**Cancer**	**Yes** or **No**
Heart Murmur	**Yes** or **No**	**Sinus Problems**	**Yes** or **No**
Mitral Valve Prolapse	**Yes** or **No**	**Headaches**	**Yes** or **No**
Blood Thinners Pacemaker	**Yes** or **No**	**Hypoglycemia**	**Yes** or **No**
Abnormal Blood Pressure	**Yes** or **No**	**Epilepsy**	**Yes** or **No**
Diabetes	**Yes** or **No**	**Anemia**	**Yes** or **No**
Ulcers	**Yes** or **No**	**Arthritis**	**Yes** or **No**
Tuberculosis/Lung Disease	**Yes** or **No**	**HIV/AIDS**	**Yes** or **No**
Asthma/ Hay Fever	**Yes** or **No**	**Hepatitis**	**Yes** or **No**
Hemophilia	**Yes** or **No**	**Venereal Disease**	**Yes** or **No**
	Yes or **No**	**Joint Replacement**	**Yes** or **No**

Women: Are you pregnant? **Yes** or **No** If yes, due date: _____

Are you allergic to or had any problems with the following medication:

Antibiotics	**Yes** or **No**	If yes,which one: _____
Pain Meds	**Yes** or **No**	If yes,which one: _____
Anesthetic	**Yes** or **No**	If yes,which one: _____

Other _____

Date of last dental treatment: _____ **Date of last dental xrays:** _____

Please list below any medications you are taking or any medical conditions not listed above:

_____

_____

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As a courtesy to you, our patient, we assist in filing the necessary paperwork for your dental services. However, we remind you that your specific policy is an agreement between you and your insurance company. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.
I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all cost of collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary.

I agree, in order to collect monies I may owe, Perrigo Dental Care and/or its agents may contact me by telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also be contacted by text message or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that Perrigo Dental Care, its employees and/or agents may contact me as described above.

Signature of Patient/Guardian:_____ **Date:** _____

Relationship to Patient (if patient is under 19): _____