Liza King D.M.D. Patrick Carroll D.M.D.

Name		Date of Birth		
MEDICAL HISTORY				
Please mark (x) to your r		have or have had any of the	-	
Gastrointestinal	Respiratory	Hematologic/Lymphatic	Endocrinology	Medical Allergies
Ulcers	🗆 Asthma	🗆 Anemia	Diabetes	Antibiotics
Gastrointestinal Disease	🗆 Emphysema	Blood Disorders	Hepatitis A/B/C	
🗆 Acid Reflux	Respiratory Problems	🗆 Bruise Easily	Jaundice	
Cardiovascular	🗆 Sinus Problems	Excessive Bleeding	🗆 Kidney Disease	🗆 Latex
🗆 Angina (chest pain)	🗆 Sleep Apnea	Neurological	🗆 Liver Disease	Opioids
Artificial Heart Valve	Tuberculosis	🗆 Anxiety	Thyroid Disease	- Oxycodone
Heart Conditions		Depression	Viral Infections	- Tylenol 3
High/Low Blood Pressure	Musculoskeletal	🗆 Dizziness		- Percocet
□ Heart Surgery	🗆 Arthritis	Drug/Alcohol Addiction	□ HIV Positive	Local Anesthetics
Pacemaker	Artificial Joints	□ Fainting	□ HPV	
🗆 Stroke	🗆 Jaw Joint Pain	□ Seizures	Cancer	Other Allergies:
Heart Attack	Rheumatoid Arthritis	Psychiatric Illness	Туре	
Women		\Box Autism	□ Chemotherapy	
Currently Pregnant			□ Radiation Therapy	
□ Nursing				
	erns:			
-	llness, operation, or hospit	alization in the past 5 years?	Y or N, If yes please	
		cription or over the counter and/or dietary supplements		
		r taking any medications for		sis or Bone

Have you ever had surgery? If so, what type:______

Consent:

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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient