Patient Name:____

Date ___________________

Current Medication List

Are you taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? Yes________ No_________

Please list all medications:	Reason taking:	How much:	w often:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____ ___________________

Signature of patient / legal guardian Date

FOR OFFICE USE ONLY

____ ___________________

Signature of Dentist/Hygienist. Also student if applicable Date

____ ___________________

Signature of Dentist/Hygienist. Also student if applicable Date

____ ___________________

Signature of Dentist/Hygienist. Also student if applicable Date