

Your Name _____ Phone _____

Address _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures;

Y	N	Y	N	Y	N	Y	N
		Heart Surgery	Diabetes	Low Blood Pressure	Hepatitis		
		Heart Attack	Kidney trouble	High Blood Pressure	HIV/AIDS		
		Cardiac Pacemaker	Are you on dialysis?	Tumor or growth	Are you immunosuppressed?		
		Chest Pain/Angina	Respiratory problems	Radiation / Chemotherapy	Do you smoke?		
		Mitral Valve Prolapse	Asthma	Anemia	Use Chewing Tobacco		
		Rheumatic Fever	Tuberculosis	Blood disorder	History of drug abuse?		
		Stroke	Low blood sugar	Joint/Valve replacement	Year of surgery _____		

MEDICATION AND ALLERGIES Are you now taking, or have you taken:

Y	N	Y	N	Y	N	Y	N
		Anti Anxiety	Pain killers (including Aspirin)	Muscle relaxers	Stimulants		
		Have you ever taken diet pills	Tranquilizers	Insulin	Antidepressants		
		Any bone density medication or Bisphosphonates:(Aredia, Zometa, Fosamax, Actonel)			Blood thinners (Coumiden, Plavix, Aspirin)		

Please list current Medications;

Are you allergic to or had a reaction to:

Y	N	Y	N	Y	N	Y	N
		Latex	Aspirin	Aspirin pentothal	Sulfa drugs		
		Local anesthetic (num b. Med.)	Penicillin/Amoxicillin	Valium / other tranquilizers	Codeine or other narcotics		

Others: _____

I-4 Below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? **Y N** 2) Expected delivery date _____
3) Are you nursing? **Y N** 4) Are you taking birth control pills? **Y N**

I, the undersigned patient, hereby authorize the dentist to perform the diagnostic procedures and treatment that may be necessary for proper dental care. I understand my dental condition and have discussed several treatment options with the dentist and/or hygienist.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

In case of an emergency, I authorize the undersigned provider and any other qualified assistants or medical professionals to perform any necessary procedure(s) or treatment(s). I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits, or for other health care providers.

I have been given a printed copy of the procedure or treatment details and any post-op instructions. I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider.

Signature of patient: _____ Date: _____

(Parent or Guardian if minor)