

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> A or <input type="checkbox"/> B
or Hepatitis <input type="checkbox"/> C | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | OTHER:
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |

Artificial Joints yes (if yes, please answer below) no

Total joint replacement OR Pins, Plates or screws

You've had previous infections in your artificial joint.

Date of joint surgery _____

Orthopaedic Surgeon _____ Phone# _____

Heart disease

Artificial heart valves

A history of infective endocarditis

Certain specific serious congenital (present from birth) heart conditions _____

Any repaired congenital heart defect with prosthetic material or device

a cardiac transplant that develops a problem in a heart valve

Are you **pregnant**? Yes No If yes, what month? _____ • Are you nursing? Yes No

Are you taking any type of birth control? Yes No

- **Are you taking any medications?** Yes No
If yes please list: _____
- **Are you allergic to anything?** Yes No
If yes please list: _____
- **Have you been admitted to a hospital or needed emergency care during the past two years?** Yes No
If yes, please explain: _____
- **Are you now under the care of a physician?** Yes No
If yes, please explain: _____
- **Name of Physician:** _____ **Phone:** _____
- **Do you have any health problems that need further clarification?** Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature X _____ **Date:** _____

Person to contact for emergency (not living with you)

Name _____ phone # _____

Address _____ State _____ Zip code _____

Consent for Services

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 and all forms of treatment, medication and therapy, which may be indicated in connection with **(Name of patient)** _____

And further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

X _____ Date: _____
Signature of patient,

X _____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party