MEDICAL AND ALLERGY ALERTS:

Name ______________________________

Home Phone# ______________ Work Phone # ______________

Age ________ Birthdate ______ Sex ______ Marital Status ________

Spouse/Parent ______________________________

TO BE ANSWERED BY PATIENT

	YES	NO
1. Are you taking any medication or presently under a physician's care? ______________	❑	❑
2. Please list any medications that you are currently taking. ______________ ______________ ______________	❑	❑
3. Have you ever had to take any premedication prior to your dental visits.	❑	❑
Have you ever had:		
Rheumatic Fever	❑	❑
Heart Murmur	❑	❑
Heart Trouble	❑	❑
Mitral Valve Prolapse	❑	❑
High Blood Pressure	❑	❑
Anemia	❑	❑
Diabetes	❑	❑
Pacemaker	❑	❑
Hepatitis	❑	❑
Kidney or Bladder Disease	❑	❑
Arthritis	❑	❑
Asthma or Hay Fever	❑	❑
Tuberculosis	❑	❑
Epilepsy	❑	❑
A.I.D.S.	❑	❑
Cancer	❑	❑
HIV	❑	❑
Joint / Valve Replacement	❑	❑
4. Have you ever been hospitalized in the past five years?	❑	❑

	YES	NO
5. Have you ever had severe bleeding or any other complications fòllowing an extraction?	❑	❑
6.Are you allergic to any drugs, medications or injections? ______________ ______________ ______________	❑	❑
7.Do you smoke?	❑	❑
8. Are you pregnant?	❑	❑
9.Is there anything else in your medical history of significance	❑	❑
DENTAL CONCERNS		
1. Color	❑	❑
2. Shape	❑	❑
3. Size	❑	❑
4. Alignment	❑	❑
5. Sensitive Gums	❑	❑
6. Bleeding Gums	❑	❑
7. General Sensitivity	❑	❑
8. Mobile / Loose Teeth	❑	❑
9. Bad Breath / Mouth Odor	❑	❑
10. Swelling	❑	❑
11. Recent Changes In Oral Tissue	❑	❑
12. Dry Mouth	❑	❑
13. Missing Teeth	❑	❑
14. Dentures / Partials	❑	❑
15. Grinding / Clenching	❑	❑
16. Other Dental Concerns	❑	❑

1. Before treatment can be rendered, adequate radiographs of the teeth and mouth must be taken.

2.In this office we use local anesthetic and other methods of pain control to make our patients more comfortable while receiving dental treatment.

3.Unless otherwise arranged, payment for professional service is required ***on the day the treatment is rendered.*** With prior approval, on certain extended procedures and treatment, payment plans can be arranged.

4. Please give at least 24 hours notice if you cannot keep your appointment, otherwise you may be charged a minimum of $25.00.

Consent for Procedures

This is to certify that I, undersigned, consent to the performing of the procedures agreed upon, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those

procedures.

Patient's (Parent's) Signature ______________________ Date ____________

Referred by ______________________________

FOR OFFICE USE ONLY

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