

HEALTH HISTORY

PATIENT NAME: _____

Date: _____

DENTAL HISTORY

Reason for Today's visit: _____

Date of last dental care: _____

Former Dentist: _____

Date of last dental x-ray: _____

Check (/) if you have or have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth of broken fillings | <input type="checkbox"/> Sensitivity or growth in your mouth |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Periodontal treatment | |

MEDICAL HISTORY

Physician's Name: _____

Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine)? YES NO

Have you ever been treated for osteoporosis with injectable Bisphosphonates? YES NO

Have you had any spinal or hip fractures? YES NO

Have you now or have you ever smoked? YES NO

Have you ever had any serious illness or operation? YES NO, if yes, Describe: _____

Have you ever had a blood transfusion? YES NO, if yes, give approximate date: _____

WOMEN- Are you pregnant? YES NO Taking Birth control pills? YES NO

Check (/) if you have or have had problems with any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, etc | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling of feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Circulatory Problems |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Cholesterol |

List medications you are currently taking:

ALLERGIES:

- | | | | |
|--|---|---------------------------------|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> None | |

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent
Guardian or Personal Rep.

Print name of Patient
Parent, Guardian or Personal Rep

Relationship to Patient.

PREVENTATIVE CARE HEALTH SERVICES

DENTAL CLINIC

DENTAL TREATMENT CONSENT

DENTIST'S NAME: _____

PATIENT'S NAME: _____

DATE: _____

PLEASE READ AND INITIAL THE ITEMS BELOW AND SIGN AT THE BOTTOM OF THE FORM

- DENTAL EXAMINATIONS:** I understand that a visual oral examination must be completed in order to diagnose any dental problems. I understand that I can elect to have a limited examination that focuses on the main concern/acute problem or a full comprehensive examination that includes a complete thorough evaluation covering everything from new and pre-existing conditions, periodontal conditions, and extraoral and intraoral hard and soft tissues. I further understand that a comprehensive exam is recommended for all new patients or established patients who have been absent from active treatment for three or more years.
- X-RAYS:** I understand that for accurate diagnosis and treatment of any possible dental conditions in my mouth dental x-rays must be obtained. I understand that single or multiple x-rays consisting of diverse radiographic images might be needed to have a more accurate diagnosis. I further understand that x-rays can also serve as evidence for dental diagnosis and/or treatment completed.
- WORK TO BE DONE:** I understand that dental work has been recommended to be completed as it is detailed in the treatment plan presented to me. I understand that for procedures such as but not limited to Extractions, Crowns, Bridges and Veneers, Post and Core, Root Canals, Completed or Partial Dentures, Periodontal and Bleaching, I will be giving an additional consent form to authorize the specific procedure.
- Changes in Treatment plan:** I understand that during treatment it may be necessary to change or add procedures due to new conditions found while working on teeth that were not visible at the time of examination or x-rays.
- Further Dental Treatment:** I understand I may need further dental treatment by a specialist or even hospitalization if complications arise during or following treatment.
- Changes in pricing:** I understand that changes in my treatment plan can occur and can have an effect on pricing. I further understand that any referred treatment to a specialist or hospital will create separate charges, that cost will be my responsibility to pay through insurance or as an out-of-pocket expense.
- Dental Benefits:** I understand that my insurance may provide only minimum standard care. I elect to follow the doctor's recommendation and/or optional dental treatment including all cosmetic procedures not covered by my dental insurance that will be my responsibility to pay. I understand that having dental insurance does not guarantee full coverage or payment of dental treatment procedures. I understand that if my dental treatment/procedure is not covered by my dental insurance, I will be responsible for full payment or any remaining balance.
- I Give my permission to the dentist to make any/all changes and additions as necessary.**

*****I understand that dentistry is not an exact science and that; reputable practitioners cannot properly guarantee results.***I acknowledge no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to proposed treatment****

Signature of patient: _____ Date: _____

Signature of parent/ guardian if patient is a minor: _____ Date: _____

Signature of witness: _____ Date: _____