# Patient Information

Date _____

Patient's Name _____ Age _____ Patient's Birthday _____ ■ Male □ Female
Last First Initial

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Address _____
Street City Zip

Email : _____ Cell Phone (_____) _____

Social Security No._____ **OR** Driver's License _____

Emergency Contact:_____ Res. Phone (_____) _____

Name of Physician _____ ■ I have no Physician Ofc. Phone (_____) _____

## EXAMINATION & X-RAYS:

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. The undersign hereby authorizes the Doctor to take x-rays, study models, photographs of mouth or teeth, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

(initials _____)

## CONSENT FOR TREATMENT

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. **All services are rendered and accepted under the terms and conditions printed on the reverse hereof: Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.**

**Signature:** _____ **Relation:** _____ **Date:** _____

## TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.
I grant my permission to you, or your assigns to telephone me at home or at my work to discuss matters related to this form. I grant my permission to you, or your assigns to send text messages and/or emails to numbers and addresses provided by me in regards to any matters related to services rendered by this office.
**I have read the above conditions of treatment and agree to their content:**

Signature: _____ Relation: _____ Date: _____

**FLIP TO BACK PAGE** □

# HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question.
Check the appropriate box and/or check **YES** or **NO** where applicable.

**MEDICAL HISTORY**

Are you in good health? ☐ **Yes** ☐ **No** Date of last physical examination: _____

Are you now under the care of a physician? ☐ **Yes** ☐ **No** If so, what is the condition being treated? _____

Have you ever had any serious illness or operation? ☐ **Yes** ☐ **No** If so, what illness or operation? _____

Have you ever been hospitalized? ☐ **Yes** ☐ **No** If so, what was the problem? _____

Are you taking any ☐ medications ☐ drugs ☐ herbs ☐ **Yes** ☐ **No** If so, what? _____ Dosage? _____

Are you using any recreational drugs? ☐ **Yes** ☐ **No** If so, what? _____(marijuana, cocaine, etc.)

Have you ever been pre-medicated with antibiotics for your dental treatment? ☐ **Yes** ☐ **No**

Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other ☐ **Yes** ☐ **No**

**Do you have any of the following**: (Please **Check** for yes and **Blank** for no. Answer ALL conditions)

| | | | | | |
|---|---|---|---|---|---|
| ☐ Anemia | ☐ Implant(s) | ☐ Head Injuries | ☐ Drug Addiction | ☐ Blood Transfusion | ☐ Excessive Bleeding |
| ☐ Herpes | ☐ Headaches | ☐ Heart Failure | ☐ Kidney Disease | ☐ Joint Replacement | ☐ Mitral Valve Prolapse |
| ☐ Stroke | ☐ Glaucoma | ☐ Scarlet Fever | ☐ Chemotherapy | ☐ Nervous Disorders | ☐ High Blood Pressure |
| ☐ Ulcers | ☐ Tonsilitis | ☐ Sinus Trouble | ☐ Stomach Ulcers | ☐ Tumors or Growths | ☐ HIV Related Complex |
| ☐ Diabetes | ☐ Hemophilia | ☐ Heart Murmur | ☐ Angina Pectoris | ☐ Allergies or Hives | ☐ Respiratory Disease |
| ☐ Arthritis | ☐ Cold Sores | ☐ Liver Disease | ☐ Mental Disorder | ☐ Pain in Jaw Joints | ☐ Epilepsy or Seizures |
| ☐ Asthma | ☐ Emphysema | ☐ AIDS | ☐ Thyroid Disease | ☐ Artificial Prosthesis | ☐ Psychiatric Treatment |
| ☐ Cancer | ☐ Rheumatism | ☐ Heart Ailments | ☐ Fainting Spells | ☐ Sickle Cell Disease | ☐ Hepatitis or Jaundice |
| ☐ Seizures | ☐ Chicken Pox | ☐ Heart Attack | ☐ Rheumatic Fever | ☐ Cortisone Medicine | ☐ Difficulty Swallowing |
| ☐ Hay Fever | ☐ Bruise Easily | ☐ Cerebral Palsy | ☐ Tuberculosis T.B. | ☐ Allergies to Metals | ☐ Snoring |
| ☐ Sleep Apnea | ☐ TMJ | ☐ Blood Disease | ☐ Venereal Disease | ☐ Osteoporosis | |
| ☐ X-ray or Cobalt treatment | | ☐ Congenital Heart Lesions | | ☐ Radiation Treatment of any kind | |

Do you have any disease, condition or problem not listed that you think we should know about? ☐ **Yes** ☐ **No**

If so, what? _____

Do you wear a cardiac pacemaker or have you had heart surgery? ☐ **Yes** ☐ **No**

Do you smoke? **Yes** **No** If yes, how much? _____

Have your ever taken the drugs ☐ Fen-Phen ☐ Redux or any ☐ Diet Drugs ☐ **Yes** ☐ **No**

**Women:** Are you pregnant? ☐ **Yes** ☐ **No** If so, how many months? _____

**Dental History:**

Have you ever had a local anesthetic? ☐ **Yes** ☐ **No**
Have you ever had an unfavorable reaction from a local anesthetic? ☐ **Yes** ☐ **No**
Have you had any serious trouble associated with any previous dental work? ☐ **Yes** ☐ **No**

If so, please explain:

_____

How long since your last dental treatment? _____

Does dental treatment make you nervous? ☐ **Yes** ☐ **No** ☐ Slightly ☐ Moderately ☐ Extremely

Would your desire to be pre-sedated? ☐ **Yes** ☐ **No**

**Reviewed by**: _____ (For staff use)