

HEALTH HISTORY

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 or HIV+ | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Growths | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Psychological Care | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Cold Sore/Fever Blister | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | |

Please List All Medications _____

Please List All Allergies _____

- Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please explain: _____
- Have you ever had any complications following dental treatment? Yes No
If Yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If Yes, please explain: _____
- Are you under the care of a physician? Yes No
If Yes, please explain: _____
- Name of Physician: _____ Phone: _____
- **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking Birth Control?** Yes No

INFORMED CONSENT STATEMENT

This is to certify that I consent and hereby authorize and request the performance upon myself/child/dependent of any needed dental or oral surgical procedure as recommended to me by the dentist. I also authorize and request the administration of anesthetic(s) for myself/my minor child/my dependent as may be deemed necessary or advisable by the doctor. I acknowledge the possible risks and complications involved during and after the performance of all dental procedures, surgeries and delivery of anesthetic. I also acknowledge that I will have the opportunity to ask and have any and all of my questions regarding these risks answered before treatments begin. I fully understand that during, and following the contemplated procedures, surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternate treatment pertinent to the success of comprehensive treatment. I also approve of any modifications in design, materials or care if it is felt that it is for my best interest. I have been informed and understand that the practice of dentistry is not an exact science and that no guarantees or assurances as to the outcome of dental treatment or surgery can be made.

Signature of Patient or Guardian _____

Witness _____ **Date** _____