



| Past Medical History | List all MEDICATIONS (include over-the-counter) <input type="checkbox"/> No medications | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---------|---------------------|-------------|---|---------|---------------------------|--------|---|---------|---------|-----------------------|--|--|--|---------------------|--|--|--|------|--|--|--|---------------------|--|--|--|-------------------|--|--|--|-----------|--|--|--|---|--|--|--|----------------|--|--|--|--------|--|--|--|--|--|--|--|-------------------|--|--|--|---------------------|--|--|--|--------------------------------------|--|--|--|--------------|--|--|--|-------------------------|--|--|--|--|--|--|--|----------|--|--|--|--------------------|--|--|--|--|--|--|--|----------|--|--|--|--------------------------|--|--|--|--|--|--|--|----------------|--|--|--|---------------------------|--|--|--|--|--|--|--|-----|--|--|--|-------------|--|--|--|------------------|--|--|--|------|--|--|--|--------|--|--|--|-------------------------------------|--|--|--|-----------|--|--|--|---------------|--|--|--|--|--|--|--|--------|--|--|--|----------|--|--|--|--|--|--|--|------------------|--|--|--|----------|--|--|--|--|--|--|--|--|--|---------------|---|---|------------|--|--|-------|--|--|-------|--|--|---------|--|--|-----------|--|--|
| Physician Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician Phone: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of last exam: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;"></th> <th style="width:5%;">Y</th> <th style="width:5%;">N</th> <th style="width:10%;">details</th> <th style="width:20%;">History of?</th> <th style="width:5%;">Y</th> <th style="width:5%;">N</th> <th style="width:10%;">details</th> <th style="width:20%;">Asthma</th> <th style="width:5%;">Y</th> <th style="width:5%;">N</th> <th style="width:10%;">details</th> </tr> </thead> <tbody> <tr> <td>Do you drink alcohol?</td> <td></td><td></td><td></td> <td>Heart Valve Surgery</td> <td></td><td></td><td></td> <td>COPD</td> <td></td><td></td><td></td> </tr> <tr> <td>Do you use tobacco?</td> <td></td><td></td><td></td> <td>Bleeding Disorder</td> <td></td><td></td><td></td> <td>Emphysema</td> <td></td><td></td><td></td> </tr> <tr> <td>Do you have a history of substance abuse?</td> <td></td><td></td><td></td> <td>Blood Thinners</td> <td></td><td></td><td></td> <td>Stroke</td> <td></td><td></td><td></td> </tr> <tr> <td></td> <td></td><td></td><td></td> <td>Joint Replacement</td> <td></td><td></td><td></td> <td>High Blood Pressure</td> <td></td><td></td><td></td> </tr> <tr> <td>Are you under medical treatment now?</td> <td></td><td></td><td></td> <td>Heart Murmur</td> <td></td><td></td><td></td> <td>Heart Disease/Pacemaker</td> <td></td><td></td><td></td> </tr> <tr> <td></td> <td></td><td></td><td></td> <td>Leukemia</td> <td></td><td></td><td></td> <td>Low Blood Pressure</td> <td></td><td></td><td></td> </tr> <tr> <td>Have you ever been hospitalized for any surgical operation or serious illness?</td> <td></td><td></td><td></td> <td>Diabetes</td> <td></td><td></td><td></td> <td>Radiation / Chemotherapy</td> <td></td><td></td><td></td> </tr> <tr> <td></td> <td></td><td></td><td></td> <td>Kidney Disease</td> <td></td><td></td><td></td> <td>Oral / Head / Neck cancer</td> <td></td><td></td><td></td> </tr> <tr> <td>Are you pregnant or think you may be pregnant?</td> <td></td><td></td><td></td> <td>HIV</td> <td></td><td></td><td></td> <td>Ulcers/GERD</td> <td></td><td></td><td></td> </tr> <tr> <td>Are you nursing?</td> <td></td><td></td><td></td> <td>AIDS</td> <td></td><td></td><td></td> <td>Cancer</td> <td></td><td></td><td></td> </tr> <tr> <td>Are you taking birth control pills?</td> <td></td><td></td><td></td> <td>Hepatitis</td> <td></td><td></td><td></td> <td>Liver Disease</td> <td></td><td></td><td></td> </tr> <tr> <td></td> <td></td><td></td><td></td> <td>Anemia</td> <td></td><td></td><td></td> <td>Seizures</td> <td></td><td></td><td></td> </tr> <tr> <td></td> <td></td><td></td><td></td> <td>Thyroid disorder</td> <td></td><td></td><td></td> <td>Fainting</td> <td></td><td></td><td></td> </tr> </tbody> </table> | | Y | N | details | History of? | Y | N | details | Asthma | Y | N | details | Do you drink alcohol? | | | | Heart Valve Surgery | | | | COPD | | | | Do you use tobacco? | | | | Bleeding Disorder | | | | Emphysema | | | | Do you have a history of substance abuse? | | | | Blood Thinners | | | | Stroke | | | | | | | | Joint Replacement | | | | High Blood Pressure | | | | Are you under medical treatment now? | | | | Heart Murmur | | | | Heart Disease/Pacemaker | | | | | | | | Leukemia | | | | Low Blood Pressure | | | | Have you ever been hospitalized for any surgical operation or serious illness? | | | | Diabetes | | | | Radiation / Chemotherapy | | | | | | | | Kidney Disease | | | | Oral / Head / Neck cancer | | | | Are you pregnant or think you may be pregnant? | | | | HIV | | | | Ulcers/GERD | | | | Are you nursing? | | | | AIDS | | | | Cancer | | | | Are you taking birth control pills? | | | | Hepatitis | | | | Liver Disease | | | | | | | | Anemia | | | | Seizures | | | | | | | | Thyroid disorder | | | | Fainting | | | | <p>List any other conditions / details / explanations :</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;">ALLERGIC TO ?</th> <th style="width:5%;">Y</th> <th style="width:5%;">N</th> </tr> </thead> <tbody> <tr><td>Penicillin</td><td></td><td></td></tr> <tr><td>Sulfa</td><td></td><td></td></tr> <tr><td>Latex</td><td></td><td></td></tr> <tr><td>Codeine</td><td></td><td></td></tr> <tr><td>Lidocaine</td><td></td><td></td></tr> </tbody> </table> <p>List all ALLERGIES: <input type="checkbox"/> No allergies</p> | | | | | | ALLERGIC TO ? | Y | N | Penicillin | | | Sulfa | | | Latex | | | Codeine | | | Lidocaine | | |
| | Y | N | details | History of? | Y | N | details | Asthma | Y | N | details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you drink alcohol? | | | | Heart Valve Surgery | | | | COPD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you use tobacco? | | | | Bleeding Disorder | | | | Emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have a history of substance abuse? | | | | Blood Thinners | | | | Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Joint Replacement | | | | High Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you under medical treatment now? | | | | Heart Murmur | | | | Heart Disease/Pacemaker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Leukemia | | | | Low Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever been hospitalized for any surgical operation or serious illness? | | | | Diabetes | | | | Radiation / Chemotherapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Kidney Disease | | | | Oral / Head / Neck cancer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you pregnant or think you may be pregnant? | | | | HIV | | | | Ulcers/GERD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you nursing? | | | | AIDS | | | | Cancer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you taking birth control pills? | | | | Hepatitis | | | | Liver Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Anemia | | | | Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Thyroid disorder | | | | Fainting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ALLERGIC TO ? | Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Penicillin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sulfa | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Latex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Codeine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Lidocaine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
 Signature of patient or guardian if minor

Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights were given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved in my treatment);
- Obtaining payment from third party payors (e.g., my insurance company);
- The day-to-day operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

X _____
 Signature of patient or guardian if minor

X _____
 Date