

HEALTH INFORMATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING: PLEASE CHECK THOSE THAT APPLY:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Kidney Disease | Date: _____ |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cold sore |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Are You Currently Pregnant? | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Epilepsy | Due Date: _____ | <input type="checkbox"/> Allergies/Seasonal |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> LATEX Allergy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other: _____ |

Date: _____

Please list all medications and Pharmacy: _____

When was your last dental visit/cleaning: _____

Reason for this visit: _____

Have you ever had any complications following dental treatment Yes No

If yes please explain: _____

Are you now under the care of a physician: Yes No

If yes please explain: _____

Name of Physician: _____ Phone: _____

Consent For Services

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said service are rendered. I further agree that waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees of suit be instituted hereunder.

X _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian.

Consent to File Insurance or responsible for payment

Patients who carry dental insurance understand that dental services furnished are charged directly to the patient and he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I grant permission to this office to release any records, x-rays or personal information needed to the insurance company for payment of claims.

I grant permission to you or your assignee, to telephone me at my work to discuss matters related to this form.

I have read the conditions of treatment and payment and agree to content.

X _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian responsible for payment.

PLEASE SIGN BOTH OF THE ABOVE LINES