

TIME OF DAY FOR APPOINTMENTS PREFERRED: Winter _____ Summer _____

CONSENT TO TREAT CONFIDENTIAL MEDICAL HISTORY

PATIENT NAME _____ SS#: _____ BIRTHDATE _____
ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____ Male Female

HAVE YOU BEEN HAVING ANY SPECIFIC DENTAL PROBLEMS? YES NO
DESCRIBE _____

HAVE YOU EVER HAD ANY UNUSUAL EFFECTS FROM PREVIOUS DENTAL TREATMENT? YES NO
DESCRIBE _____

MEDICAL DOCTORS NAME: _____ CITY _____

ARE YOU UNDER A DOCTOR'S CARE NOW? YES NO
DESCRIBE _____

ARE YOU ALLERGIC TO LATEX GLOVES? YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
LIST _____

ARE YOU TAKING ANY MEDICATIONS, BIRTH CONTROL PILLS OR DRUGS? YES NO
LIST _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? CIRCLE YES OR NO

HEART TROUBLE	YES	NO	ARTHRITIS	YES	NO
VALVE PROBLEMS	YES	NO	EPILEPSY	YES	NO
RHEUMATIC FEVER	YES	NO	CANCER	YES	NO
HEART MURMUR	YES	NO	ASTHMA	YES	NO
HIGH BLOOD PRESSURE	YES	NO	JAUNDICE	YES	NO
PROSTHETIC JOINT	YES	NO	TUBERCULOSIS	YES	NO
DIABETES	YES	NO	MONONUCLEOSIS	YES	NO
RADIATION TREATMENT	YES	NO	PSYCHIATRIC THERAPY	YES	NO
BLOOD DISORDERS	YES	NO	COLD SORES (Herpes Simplex)	YES	NO
PROLONGED BLEEDING	YES	NO	A.I.D.S.	YES	NO
HEPATITIS	YES	NO	VENEREAL DISEASE	YES	NO
PREGNANT (NOW)	YES	NO	LOW BLOOD PRESSURE	YES	NO
FAINING	YES	NO	STROKE	YES	NO
			HIV	YES	NO

HAVE YOU HAD ANY OTHER SERIOUS ILLNESS? YES NO
EXPLAIN _____

SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING? CIRCLE YES OR NO

PENICILLIN	YES	NO	CODEINE	YES	NO
ASPIRIN	YES	NO	NOVACAINE	YES	NO
ANESTHETICS	YES	NO	OTHERS?	YES	NO

COMMENTS: _____

CHANGES (Address and/or name)

NAME _____
ADDRESS _____ CITY _____ ZIP _____
PHONE _____
EMPLOYMENT _____
INSURANCE _____

PLEASE SIGN AND DATE THE BACK

