# Medical/Consent Form

Name_____________________________________________ Birthdate____/_____/_____

Address___________________________ City_______________ State________ Zip_____________

Home# (____)_____________ Work# (____)________________ext._____ Cell# (____)________________

Email____________________________________ SSN# ______ - ______ - _______

Emergency Contact Name _______________________________ Phone # _____________________

Physician's Name__________________________________ Date of Last Visit____/____/_______

Please circle **Y** (YES) or **N** (NO) to indicate if you have or had any of the following if yes provide date:

Y N High Blood Pressure
Y N Osteoporosis
Y N Hepatits: Type___
Y N Jaw Pain
Y N Cancer
Y N Chemotherapy
Y N Radiation Therapy
Y N Epilepsy
Y N Fainting / Dizziness

Y N Artificial Heart Valves
Y N AIDS/HIV
Y N Asthma
Y N Artificial Joints
Y N Pacemaker
Y N Diabetes
Y N Stroke
Y N Smoke (cigarettes, cigars, pipe)
Y N Smokeless Tobacco

Y N Sinus Trouble
Y N Oral Contraceptives
Y N Are you pregnant?
Due Date:___/___/___
Y N Are you nursing?

Please circle **Y** (YES) or **N** (NO) if you have any of the following **ALLERGIES**:

Y N Aspirin
Y N Barbiturates
Y N Codeine

Y N Latex
Y N Local Anesthetics
Y N Penicillin/Amoxicillin

Y N Sulfa
Y N Other Antibiotic_______
Y N Other________________

Do you Premedicate before dental visits? Y N If so, name of antibiotic taken __________________________

Please list **ALL MEDICATIONS** you are currently taking:__________________________________________

___________________________________________________________________________________

**Treatment Authorization:** I authorize and give consent to perform dental services agreed upon between doctor and patient and/or guardian, which have been deemed necessary or advisable to maintain my dental health; including necessary x-rays.

**Notice of Privacy Practices (HIPPA)** I have read and/or received a copy.

**Financial Responsibility**
I authorize the release of all information necessary to secure any insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance.

Patient Signature ____________________________________________ Date: ____/_____/____

Guarantor Signature (If different than Patient)______________________________ Date:____/_____/____