Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications you may be taking could have an important interrelationship with the dental treatment you receive. Thank you for answering the following questions.

Are you under the care of a physician? ___Yes ___No Name/Address ______________________________

Have you ever been hospitalized? ___Yes ___No Explain: ______________________________

Have you had a head or neck injury? ___Yes ___No Explain: ______________________________

Are you taking any medications, pills or drugs? ___Yes ___No Explain: ______________________________

Have you taken Phen-Fen or Redux? ___Yes ___No Explain: ______________________________

Have you used or do you use tobacco? ___Yes ___No Explain: ______________________________

Have you had weight loss surgery? ___Yes ___No Explain: ______________________________

Have you taken osteoporosis meds? ___Yes ___No Explain: ______________________________

WOMEN: Are you pregnant? Yes ___ No ___ Trying to get pregnant? Yes ___ No ___ Taking oral contraceptives? Yes ___ No ___ Nursing? Yes ___ No ___

ALLERGIES: None ___ Acrylic ___ Aspirin ___ Codeine ___ Latex ___ Local Anesthesia ___ Metal ___ Penicillin ___ Other ______________________________

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

___AIDS/HIV Positive
___Alzheimer/Dementia
___Anaphylaxis
___Anemia/Low Iron
___Angina/Chest Pains
___Arthritis
___Artificial Heart Valve
___Artificial Joint
___Asthma
___Blood Disease
___Blood Transfusion
___Breathing Problems
___Bruise Easily
___Cancer
___Chemotherapy
___Cold Sores
___Chest Pain
___Congenital Heart Defect
___Convulsions/Seizures
___COPD
___Diabetes I / Diabetes II
___Easily Winded
___Emphysema
___Epilepsy
___Excessive Bleeding
___Excessive Thirst
___Fainting/Dizziness
___Frequent Cough
___Frequent Diarrhea
___Frequent Headaches
___Genital Herpes
___Glaucoma
___Gout
___Hay Fever
___Heart Arrhythmia
___Heart Attack
___Heart Disease
___Heart Murmur
___Heart Pacemaker
___Hemophilia/Clotting
___Hepatitis – A B C
___High Blood Pressure
___Hives/Rash
___High Blood Pressure
___Hives/Rash
___Hypoglycemia
___Jaw Joint Pain
___Kidney Disease/Dialysis
___Liver Disease
___Low Blood Pressure
___Mitral Valve Prolapse
___Psychiatric Care
___Radiation Treatments
___Recent Weight Loss
___Rheumatic Fever
___Scarlet Fever
___Shingles
___Sickle Cell Disease
___Sinus Problems
___Stomach Problems
___Stroke/Aneurysm
___Swelling of Limbs
___Thyroid Disease
___Tumors/Growths
___Venereal Disease
___Yellow Jaundice

Have you had any serious illness not listed above? Yes ___ No ___ Explain: ______________________________

Have you ever had an unfavorable reaction to local anesthetic or dental treatment? Yes ___ No ___ Explain: ______________________________

Does dental treatment make you nervous? Yes _____ No _____ Slightly _____ Extremely _____ Would you like to be pre-sedated? Yes _____ No _____ Possibly _____

To the best of my knowledge, all of the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in medical status.

______________________________ ______________________________ ______________

PRINTED NAME of PATIENT or LEGAL GUARDIAN **SIGNATURE of PATIENT or LEGAL GUARDIAN** **DATE**

CONSENT FOR TREATMENT:

I hereby grant authority to Carl J. Dispenziere, D.D.S. to administer anesthetics, analgesics, sedatives, nitrous oxide sedation and other drugs/medications, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications related to the procedures, anesthetics, analgesics, nitrous oxide and/or other drugs/medications.

All services are rendered and accepted under the terms and conditions originally signed by the patient, the patient's parent, or the patient's legal guardian and will remain valid until written request to terminate this contract is made by the patient, the patient's parent or the patient's legal guardian and received by Carl J. Dispenziere, D.D.S. I hereby agree to all terms and conditions of this contract.

______________________________ ______________________________ ______________

PRINTED NAME of PATIENT or LEGAL GUARDIAN **SIGNATURE of PATIENT or LEGAL GUARDIAN** **DATE**

REVIEWED BY: ______________________________ LICENSE #: ____________________ DATE: ____________________