Pt name: Cell ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?

**Conditions:**

* **None**
* Abnormal Bleeding
* Alcohol Abuse
* Allergies
* Anemia
* Angina Pectoris
* Arthritis
* Artificial Heart Valve
* Asthma
* Blood Transfusion
* Cancer
* Chemotherapy
* Colitis
* Congenital Heart Defect
* Diabetes
* Difficulty Breathing
* Drug Abuse
* Emphysema
* Epilepsy
* Facial Surgery
* Fainting Spells
* Fever Blisters
* Frequent Headaches
* Glaucoma
* HIV+ Aids
* Heart Attack
* Heart Murmur
* Heart Surgery
* Hemophilia
* Hepatitis A
* Hepatitis B
* Hepatitis C
* High Blood Pressure
* Joint Replacement
* Kidney Problems
* Liver Disease
* Low Blood Pressure
* Mitral Valve Prolapse
* Pace Maker
* Psychiatric Problems
* Radiation Therapy
* Rheumatic Fever
* Seizures
* Sexually Transmitted Disease
* Shingles
* Sickle Cell Disease
* Sinus Problems
* Stroke
* Thyroid Problems
* Tuberculosis
* Ulcers

**Allergies**

* Aspirin
* Codeine
* Dental Anesthetics
* Erythromycin
* Latex
* Metals
* Penicillin
* Sulfa
* Tetracycline
* **None**

**Y N**

❑ ❑ Do you Smoke

or use Tobacco?

**If Female**

**Y N**

❑ ❑ Are you taking Birth Control Pills?

❑ ❑ Are you pregnant?

If yes, # of weeks

❑ ❑ Are you nursing?

Please list any medications

You are currently taking:

List surgeries you had in the past:

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE DATE