MEDICAL HISTORY

Patient Name:_____ Date of Birth:___/___/___

Physician's Name:_____ Phone:(__)____-_____

Who was your previous dentist?_____

How long ago did you last see a dentist?_____

Fill every blank with either a "YES" or a "NO" (specify when appropriate)

Have you had an unusual reaction to or are allergic to any of the following drugs: Penicillin____; Aspirin___; Acetaminophen___; Ibuprofen___; Codeine___; Barbiturates___; Sulfa Drugs___; Other?(please specify)_____

Have you ever had: Rheumatic fever___; Asthma___; Any blood disorder___; Diabetes____; Rheumatism____; Arthritis___; Tuberculosis___; Venereal disease___; Heart attack____; Kidney disease___; Immune system disorders___; Other diseases?(if so, specify) _____ _____.

Circle the correct answer "Yes" or "NO" (specify when appropriate)

YES NO Do you consider yourself to be in good health?
YES NO Are you now or have you been under a physician's care with in the past year?(if YES please specify):_____
YES NO Do you take any medications, including birth control pills? (if YES, specify name and purpose for medications):_____ _____
YES NO Do you have or have you ever had bleeding or sensitive gums?
YES NO Are you now in pain?
YES NO Do you have any other allergies? (if YES please describe):_____ _____
YES NO Are you allergic to any local anesthetic?
YES NO Have you ever had any severe reaction to dental treatment or local anesthetics?
YES NO Have you ever been diagnosed as being HIV positive or having AIDS?
YES NO Do you have or have you ever had heart or blood problems?
YES NO Have you ever been told that you have a heart murmur?
YES NO Do you have or have your ever had high blood pressure?
YES NO Do you bleed or bruise easily?
YES NO Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint?
YES NO Are you subject to fainting?
YES NO Have you ever had hepatitis or liver disease?
YES NO Have you ever had a nervous breakdown or undergone psychiatric treatment?
YES NO Have you ever received counseling for excessive use of alcohol and or prescription drugs?
YES NO Women: Are you pregnant?

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability.

Signature_____ Date:___/___/___
(patient, legal guardian or authorized agent of patient)

CONSENT TO PROCEED

I authorize Dr. Perkins and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, Which may include, but are not limited to bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, bin rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing of the jawbones following oral surgery.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____ Date:_____
(Patient, Legal guardian or authorized agent of patient)

Witness:_____ Date:_____