SARAH HAVEN DAVIS, DMD

Name:_____ DOB: _____

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? _____ Date of last exam: _____

Name of Physician: _____ Phone: _____

Have you ever been hospitalized or had a major operation? _____

Have you ever had a serious head or neck injury? _____

Are you taking any medications, pills, or drugs? _____

Do you take, or have you taken, Phen-Fen or Redux? _____

Are you on a special diet? _____

Do you use tobacco? _____

Do you use controlled substances? _____

Have you ever had any complications following dental treatment? _____

Have you ever had any serious illness not listed above? If yes, please explain:

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Hiv/Aids
- ☐ Jaundice
- ☐ Joint Replacements
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy: Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Other: _____

_____

_____

General Consent

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

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

Treatment to be provided:

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues: pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I give permission to the dental office to bill my dental insurance provider for the treatment provided.

_____ _____

Patient/Guardian Signature Date