In order to properly diagnose and treat dental problems we require, and it is recommended by the American Dental Association that a full series of x-rays and/or a Panorax x-ray be taken every 3–5 years. This will incur an additional cost that may not be covered by your insurance.

_____ I agree to this treatment.

_____ I hereby waive the need for this treatment and fully understand the risks involved with not having routine dental x-rays.

HEALTH HISTORY

Physician's Name _____ Phone No. _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

HAVE YOU BEEN ADVISED BY YOUR PHYSICIAN THAT YOU NEED TO BE PRE-MEDICATED FOR DENTAL TREATMENT? ☐ YES ☐ NO

AIDS	☐ YES ☐ NO	Fainting or dizziness	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Respiratory Disease	☐ YES ☐ NO
Arthritis, Rheumatism	☐ YES ☐ NO	Headaches	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Artificial Heart Valves	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Problems	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Bleeding abnormally, with extractions or surgery	☐ YES ☐ NO	Hepatitis Type _____	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Stents	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Chemical Dependency	☐ YES ☐ NO	HIV Positive	☐ YES ☐ NO	Swollen Neck Glands	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Jaw Pain	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Congenital Heart Lesions	☐ YES ☐ NO	Joint Replacement (Knee, Hip, etc.)	☐ YES ☐ NO	Tumor or growth on head or neck	☐ YES ☐ NO
Cortisone Treatments	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO	Ulcer	☐ YES ☐ NO
Cough, persistent or bloody	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Depression	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO		
Diabetes	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO		
Emphysema	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO		
Epilepsy	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO		

Women:
Are you pregnant? ☐ YES ☐ NO
Due Date _____
Are you nursing? ☐ YES ☐ NO

MEDICATIONS

Have you ever taken any of the following medications?

FOSAMAX _____ BONIVA _____ ACTONEL _____

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Other _____
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Latex

Doctor's Signature: _____ Date: _____

Date	Update	Signature