MEDICAL HISTORY

Patient _____ Birth Date _____

Pharmacy Name _____ Pharmacy Phone Number _____

Are you allergic to any medications? Yes No Are you allergic to latex? Yes No

Are you allergic to any metals? Yes No

List all medications you are allergic to: _____

Are you taking any medications now? Yes No Herbals or dietary supplements? Yes No

List all medications and supplements you presently take: _____

_____

WOMEN, Are you Pregnant? ***Yes*** ***No*** ***Months Gestation*** _____

Do you think you are pregnant? ***Yes*** ***No*** ***Taking Birth Control Pills?*** ***Yes*** ***No***

Are you nursing? ***Yes*** ***No***

Have you ever had problems with dental anesthetics? Yes No Explain: _____

How long since your last Dental Visit? _____ Dental Cleaning? _____ X-Rays? _____

What brings you to our office? _____ Do you have dental phobias? _____

Have you ever considered straightening your teeth or improving your smile? _____

Your Overall General Health Is: Excellent / Good / Fair / Poor Major Surgeries in last 5 years: _____

Do you smoke, use tobacco, alcohol or drugs? _____ If yes: how often? _____

Physician's Name: _____ Physician's Phone Number: _____

Is there any health issue you would like to discuss with the Doctor or office member privately? Yes No

Please circle any of the following which apply to you either in the past or present:

Heart Disease or Murmur, Congenital Heart Lesions
Mitral Valve Prolapse / MVP
Rheumatic Fever
High Blood Pressure / Low Blood Pressure
Sleep Apnea / CPAP
Lung Disease or Tuberculosis
Stroke
Diabetes
Glaucoma
Muscular Dystrophy /Epilepsy / Seizures
Hepatitis
Fainting Spells
Joint Replacement (When/What) _____
Dental Implant (When/What) _____
Cancer (Type/Treatment) _____

Night Sweats
Allergies-Seasonal or other: _____
Jaundice
Drastic Weight Loss
Atrial Fibrillation
Asthma / Hay Fever
Migraine Headaches
Sinus Trouble
Excessive Thirst or Urination
Ulcers
Anemia
Blood Transfusion or Prolonged Bleeding
Arthritis
Lymph Node Enlargement (Swollen Glands)
Thyroid Problems _____

If you have circled any of the above or indicated "yes" please explain below: _____

_____

Consent for Treatment

I hereby authorize Dr. Sandford, her Associate, or her Designated Team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Sandford or her Associate to make a thorough diagnosis of my or my dependent's dental needs. Upon such diagnosis, I authorize Dr. Sandford or her Associate to perform all recommended treatment mutually agreed upon by me and Dr. Sandford or her Associate and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and or other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete description of any possible complications. I agree to be responsible for payment and services rendered on my behalf and of my dependents. I understand payment is due in full at the time of service unless other arrangements have been made prior to my treatment.

Acknowledgment and Release

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Should further medical information be needed, you have my permission to ask the respective health care provider or agency, which may release it to this office.

A parent or legal guardian must sign below if the patient is less than 18 years old.. If you were assisted with this form please enter the name and phone number of the person assisting you today: _____

Patient Signature _____ Date _____ Witness _____

Dentist Signature _____ Date _____