**HEALTH HISTORY**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.’s Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary reason for this dental appointment: Exam Emergency Consultation

Please answer the following questions as completely as possible. (Circle YES or NO)

**MEDICAL HISTORY**

1. Do you consider yourself to be in good health? …………………………………………………………………. YES NO
2. Are you now or have you been under a physician’s care within the past year? ........................................ YES NO

If yes, specify condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you take any medications? Please specify name and purpose of medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever taken Phen-Fen or similar appetite suppressants? ……………………………………………. YES NO
3. Have you ever taken Bisphosphonate medications (Fosamax, Boniva, Actonel, Reclast, Didronel, Aredia,

Zometa, Bonefos)? These medications are for treatment of osteoporosis, Paget’s Disease, and Cancer ………..… YES NO

1. Have you ever had an unusual reaction or are you allergic to any medications or substances? …………… YES NO

Aspirin \_\_\_, Penicillin \_\_\_, Acetaminophen \_\_\_, Ibuprofen \_\_\_, Codeine \_\_\_, Barbiturates \_\_\_,

Sulfa Drugs \_\_\_, Acrylic \_\_\_, Metal \_\_\_, Latex Rubber \_\_\_, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following which you have had or currently have:

* Alcohol / Drug Dependent
* Allergies or Hives
* Anemia
* Arthritis or Swollen Joints
* Artificial Heart Valve
* Artificial Joint
* Asthma
* Auto-Immune Disease
* Back Problems
* Birth Control Pills
* Blood Transfusion
* Bruise Easily
* Cancer or Chemotherapy
* Cold Sores
* Congenital Heart Defect
* Cortisone Medicine (Steroids)
* Diabetes
* Emphysema or Bronchitis
* Epilepsy or Seizures
* Fainting or Dizzy Spells
* Glaucoma
* Heart Disease or Attack
* Heart Murmur
* Heart Pacemaker
* Heart Surgery
* Hemophilia
* Hepatitis (Type\_\_\_\_\_)
* High Blood Pressure
* HIV / AIDS
* Jaundice
* Kidney Trouble
* Latex Allergy
* Liver Disease
* Low Blood Pressure
* Mental Health Problems
* Persistent Cough
* Pre-Med for Dental Work
* Pregnant (Currently)
* Radiation Therapy
* Rheumatic Fever
* Rheumatism
* Sensitive Gums
* Sexually Transmitted Disease
* Sickle Cell Disease
* Sinus Trouble
* Stroke
* Thyroid Problems
* Tobacco/Chew/Vape
* Tuberculosis/Lung Disease
* Ulcers

Do you have any medical condition or problem not listed above? If yes, Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

1. Are you now in pain? ………………………………………………………………………………………………… YES NO

2. How long ago did you last see a dentist? \_\_\_\_\_\_\_ Who was your previous dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you like your smile? ………… YES NO Why or Why Not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you allergic to any local anesthetic? ………………………………………………………………………….. YES NO

5. Do you think your teeth are affecting your general heath in any way?........................................................... YES NO

6. Do you have a specific dental problem? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have dry mouth? ……………………………………………………………………………………………. YES NO

8. Do you have jaw joint pain or clicking? …………. YES NO Do you grind your teeth? …… YES NO

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical history or in medications I take can affect dental treatment, I understand the importance of and agree to take responsibility to notify the dentist of any changes at any subsequent appointment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or Parent/Guardian

**Rosewood Professional Center**

**Family Dentistry**

**I authorize Dr. Kip Jones and/or such associates or assistants as s/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 agent(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. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.**

**I understand that as part of the 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. Dental materials and medications may trigger allergic or sensitivity reactions.**

**After lengthy appointments, jaw muscles may also be sore or tender. Holding one’s mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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, in 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, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.**

**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.**

**Signature: Date:**

**(Patient, legal guardian or authorized agent of patient)**

**Witness: Date:**

**In accordance with the Federally mandated HIPAA Act, I acknowledge that a “Notice of Privacy Practices” was made available to me by Rosewood Professional Center.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature or Parent/Guardian**