Winchester Dental

Providing gentle caring dentistry in a comfortable setting.

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication 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 physicians care now?	yes no	If yes, please explain._____
Have you ever been hospitalized or had a major operation?	yes no	If yes, please explain._____
Have you ever had a serious neck injury?	yes no	If yes, please explain._____
Are your taking any medication, pills or drugs?	yes no	If yes, please explain._____
Are you on a special diet?	yes no	If yes, please explain._____
Do you use tobacco?	yes no	If yes, please explain._____
Do you use controlled substance?	yes no	If yes, please explain._____
Are you having pain or discomfort at this time?	yes no	if yes, please explain._____
Do you feel nervous about having dental treatment?	yes no	if yes, please explain._____
Have you ever had a bad experience in the dental office?	yes no	if yes, please explain._____

Women are you:
pregnant or trying to get pregnant? yes no taking oral contraceptives yes no nursing? yes no

Are you allergic to the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other, if so please explain_____

Oy On AIDS/HIV positive	Oy On cortisone medication	Oy On hemophilia	Oy On renal dialysis
Oy On alzheimer's disease	Oy On diabetes	Oy On hepatitis A	Oy On rheumatic fever
Oy On anaphylaxis	Oy On drug addiction	Oy On hepatitis B or C	Oy On rheumatism
Oy On anemia	Oy On easily winded	Oy On herpes	Oy On scarlet fever
Oy On angina	Oy On emphysema	Oy On high blood pressure	Oy On shingles
Oy On arthritis/gout	Oy On epilepsy or seizures	Oy On hives or rash	Oy On sickle cell disease
Oy On artificial heart valve	Oy On excessive bleeding	Oy On hypoglycemia	Oy On sinus trouble
Oy On artificial joint	Oy On excessive thirst	Oy On irregular heartbeat	Oy On spina bifida
Oy On asthma	Oy On fainting spells/dizziness	Oy On kidney problems	Oy On stomach/intestinal disease
Oy On blood disease	Oy On frequent cough	Oy On leukemia	Oy On stroke
Oy On blood transfusion	Oy On frequent diarrhea	Oy On liver disease	Oy On swelling of limbs
Oy On breathing problems	Oy On frequent headaches	Oy On low blood pressure	Oy On thyroid disease
Oy On bruise easily	Oy On genital herpes	Oy On lung disease	Oy On tonsillitis
Oy On cancer	Oy On glaucoma	Oy On MVP	Oy On tuberculosis
Oy On chemotherapy	Oy On hay fever	Oy On pain in jaw joints	Oy On tumors or growths
Oy On chest pains	Oy On heart attack/failure	Oy On parathyroid disease	Oy On ulcers
Oy On cold sores/fever blisters	Oy On heart murmur	Oy On psychiatric disease	Oy On venereal disease
Oy On congenital heart disorder	Oy On heart pace maker	Oy On radiation treatment	Oy On yellow jaundice
Oy On convulsions	Oy On heart trouble/disease	Oy On recent weight loss	

Are you taking any Bisphosphonates or bone strengthening prescriptions? _____

Have you ever had any serious illness not listed above? If so, please explain._____

Comments/Current medications: _____

_____

When walking up the stairs or taking a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? yes no

Do your ankles swell during the day? yes no

Do you use more than 2 pillows to sleep? yes no

Do you ever wake up from sleep short of breath? yes no

Have you ever been diagnosed with Sleep Apnea? yes no

Do you need to be pre medicated for any reason for dental treatment? yes no

Notes:

Provider Signature _____ Date _____

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 (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian _____ *Date* _____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand to use the anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine due and payable at the time of service are rendered unless financial agreements have been made.

Patient Signature _____ Date_____ Witness _____

Parent or Responsible party _____ Relationship to patient_____