PATIENT'S NAME _____ DATE _____

DENTAL HISTORY (confidential)

Reason for today's visit _____

Date of last exam _____ Were X-rays taken? ☐ YES ☐ NO

Check (✓) if you have had any of the following:

☐ Bad breath, Chronic	☐ Grinding teeth	☐ Sensitivity to hot	☐ Wisdom teeth extraction
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweet	☐ Unfavorable reaction to dental
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting	☐ Other
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sore or growth in your mouth	

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY (confidential)

Check (✓) if you have had any of the following:

☐ AIDS	☐ Cortisone Medication	☐ Hepatitis A (Infectious)	☐ Rheumatism
☐ Anemia	☐ Cough, Persistent	☐ Hepatitis B (Serum)	☐ Scarlet Fever
☐ Angina	☐ Diabetes	☐ High Blood Pressure	☐ Shortness of Breath
☐ Arthritis, Rheumatism	☐ Drug Addiction	☐ H.I.V. Positive	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Emphysema	☐ Kidney Disease	☐ Sinus Trouble
☐ Artificial Joints	☐ Epilepsy or Seizures	☐ Liver Disease	☐ Smoke or Tobacco User
☐ Asthma	☐ Excessive Bleeding	☐ Low Blood Pressure	☐ Stroke
☐ Back Problems	☐ Fainting	☐ Mitral Valve Prolapse	☐ Swelling of Feet or
☐ Blood Transfusion	☐ Glaucoma	☐ Nervous Problems	☐ Thyroid Problems
☐ Bruise Easily	☐ Heart Attack	☐ Pacemaker	☐ Tonsils Removed
☐ Cancer	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Ulcers
☐ Chemotherapy	☐ Heart Surgery	☐ Radiation Treatment	☐ Venereal Disease
☐ Congenital Heart Lesions	☐ Hemophilia	☐ Rheumatic Fever	

Are you allergic to: ☐ Aspirin ☐ Codeine ☐ Local Anesthesia ☐ Penicillin ☐ Sulfa ☐ Other

WOMEN: Are you pregnant now? ☐ YES ☐ NO If yes, how many months? _____

Are you taking birth control pills? ☐ YES ☐ NO

CHILD: Is this the first dental visit? ☐ YES ☐ NO ☐ Thumb sucking? ☐ Tongue Thrusting?

Please list all medications you are currently taking: _____

Please list any other medical conditions or any previous experiences or problems you would like the doctor to be aware of: _____

_____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

_____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

DATE	DATE	DATE
UPDATE	UPDATE	UPDATE
SIGNATURE	SIGNATURE	SIGNATURE

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any change at any subsequent appointment.

I authorize Dr. Jarman 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, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of any dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and after completion of treatment. 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 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 may result in complications of non-healing in the jawbones following oral surgery.

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 preventative and operative treatment procedures in hopes of attaining 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 procedure 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 the patient)

Witness: _____ Date: _____