Name_____ Date_____

MEDICAL HISTORY

For the following questions, check yes or no, whichever apply. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Yes **No**

☐ ☐ 1. Are you in good health?

☐ ☐ 2. Has there been any change in your general health within the past year?

3. My last physical examination was on _____

☐ ☐ 4. Are you now under the care of a physician?

If so, what is the condition being treated? _____

5. The name, address, and phone number of my physician(s) is

_____

☐ ☐ 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?

If so, what was the illness or problem? _____

☐ ☐ 7. a. Are your currently taking or have you taken within the last week any prescription medicine(s)? If so What medicine(s) are you taking? _____

_____

☐ ☐ b. Are you currently taking or have you taken within the last week any non-prescription medicine(s), including any antihistamines, vitamins, herbal supplements, or pain relievers (such as Advil, Aleve)If so, what medicine(s) are you taking? _____

☐ ☐ 8. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)

Please Check yes or no if you have or have had any of the following

Yes	**No**		**Yes**	**No**		**Yes**	**No**	
☐	☐	Chest pain	☐	☐	Do your ankles swell	☐	☐	Inborn heart Defects
☐	☐	Shortness of breath	☐	☐	Cardiac pacemaker	☐	☐	Allergy or hay fever
☐	☐	Sinus trouble	☐	☐	Asthma	☐	☐	Fainting spells or seizures
☐	☐	Recent weight loss	☐	☐	Diabetes	☐	☐	Hepatitis/ liver disease
☐	☐	AIDS or HIV	☐	☐	Thyroid problems	☐	☐	Emphysema, bronchitis, etc.
☐	☐	Arthritis	☐	☐	Tuberculosis	☐	☐	Stomach ulcer or hyperactivity
☐	☐	Stomach ulcer	☐	☐	Kidney trouble	☐	☐	Persistent cough
☐	☐	Swollen glands in neck	☐	☐	Anorexia or bulimia	☐	☐	Epilepsy/Neurological disease
☐	☐	Cancer	☐	☐	Auto immune disorder	☐	☐	Abnormal bleeding
☐	☐	Blood transfusion	☐	☐	Blood disorder/ anemia	☐	☐	Tumor or growth

Yes No Allergic reaction to any medication including penicillin? _____

Yes No Are you/ might you be pregnant? Yes No Are you nursing?

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient Date

AUTHORIZATION FOR TREATMENT

I hereby consent to the following dental procedures to be performed by a dentist at Randolph Dental Associates:

Complete diagnosis and evaluation including x-rays, restorative procedures, oral surgery, or other dental procedures deemed necessary by the dentist including the administration of local anesthesia and/or nitrous oxide.

I understand that unforeseen conditions may be encountered which will require procedures other than those contemplated. I therefore request and authorize the dentist to perform such additional procedures as he/ she may deem necessary. The nature and risk of these procedures have been explained and I understand them. I recognize that the practice of dentistry is not an exact science, and that no guarantees have been made to me as to the result of these procedures.

I hereby agree to waive and release Randolph Dental Associates, it's dentists, and employees from all claims related to treatment rendered to me as set forth in this agreement.

Patient signature_____

FINANCIAL POLICY

Payment for services rendered is to be paid at the time of service unless other written arrangements were made prior. In the event this account is sent to a collection agency, a reasonable attorney's fee will be added to the account balance. I authorize Randolph Dental Associates to release all information necessary to secure the payment of benefits through my insurance carrier (if applicable). I understand that I will be responsible for all charges whether or not paid by insurance.

Patient signature _____

PHOTOGRAPHIC RELEASE

Photographs and x-rays may be taken during treatment, which may be necessary for ideal treatment outcomes. I consent to the release and use of this information and understand that every effort will be made to conceal my identity.

Patient signature _____