LOGAN RIDGE DENTAL

MEDICAL HISTORY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

PHYSICIAN'S NAME:_____ **PHONE:**_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

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 being treated_____		
3.	Do you take any medications, including birth control pills?	YES	NO
	Please specify name and purpose of medications:_____		
	_____		
	_____		
4.	Do you have or have you ever had any heart or blood problems?	YES	NO
5.	Have you ever been told that you have a heart murmur?	YES	NO
6.	Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?	YES	NO
7.	Do you have or have you ever had high blood pressure?	YES	NO
8.	Do you bleed or bruise easily?	YES	NO
9.	Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
10.	Have you ever had hepatitis or liver disease?		
11.	Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; venereal disease_____; heart attack_____; kidney disease_____; immune system disorders_____; other disease_____? If so, specify:	YES	NO
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetominophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other	YES	NO
13.	Are you subject to fainting?	YES	NO
14.	Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
15.	Are you allergic to any local anesthetic?	YES	NO
16.	Do you have any other allergies? If Yes, please describe:_____	YES	NO
17.	Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
18.	Have you ever received counseling for use of alcohol and/or prescription drugs?	YES	NO
19.	Women: Are you pregnant?	YES	NO
20.	Are you now in pain?	YES	NO
21.	How long ago did you last see a dentist? _____		
22.	Who was your previous dentist?_____		
23.	Do you think that your teeth are affecting your general health in any way?	YES	NO
24.	Do you have or have you ever had bleeding or sensitive gums?	YES	NO
25.	Have you ever taken Phen-Fen or similar appetite suppressants?	YES	NO
	If Yes, have you seen your physician or cardiologist for a cardiac evaluation?	YES	NO
26.	Have you ever used or are you now using tobacco or alcohol?	YES	NO
27.	Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease The resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?	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 CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ **Date**_____

(Patient, legal guardian or authorized agent of patient)

LOGAN RIDGE
DENTAL

CONSENT TO PROCEED

I authorize Dr. Cameron and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental 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. After lengthy appointments, jaw muscles may also be sore or tender. 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-ray 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.

Patient Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____