MEDICAL HISTORY and CONSENT

Although dental professionals treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Codeine	Y	N
Other	Y	N

List other known allergies:

_____

_____

_____

_____

_____

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N
Bacterial Endocarditis	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing/Vision	Y	N
Hearing Aids	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

General

Current weight: _____lbs		
Height: _____ ft _____in		
Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N
Pregnant or Nursing	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N
If yes, circle type	A B or C	

Oral

Date of last dental visit

_____

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Do you wear removable teeth?	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Have you been told you snore?	Y	N
Daytime Sleepiness	Y	N
Excessive Tiredness	Y	N
History of Hypertension	Y	N
History of Insomnia	Y	N

Social History

Do you smoke? N Y ___ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? Y N

CONFIDENTIAL

MEDICAL HISTORY and CONSENT

List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

_____

_____

_____

_____

Primary Physician's Name: _____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Stephens Gatewood & Associates to take radiographs, study models, photographs, or any other diagnostic tools deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Stephens Gatewood & Associates to perform any and all forms of treatment, medication, and therapy that may be deemed necessary by the doctors. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand the responsibility for payment of services provided for myself and my dependent(s) is mine. As a courtesy, we will be happy to assist in filing insurance. The office will collect your estimated portion on the day service is rendered and wait 30 days to obtain the balance from my insurance. I understand that I am responsible for any portion of fees not covered by my dental or medical insurance after 30 days. Stephens Gatewood & Associates and staff will provide dental care based on the patient's needs and not based on insurance coverage. I authorize Stephens Gatewood & Associates and their staff to verify insurance coverage, submit claims, and provide my insurance company with information required for processing claims. I also give permission to assign benefits directly to Stephens Gatewood & Associates and for this office to handle any necessary claim appeals on my behalf.

Consent (adult):

Name of Patient _____ _____ **Date** _____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ **Date** _____

Signature of Parent/Guardian

I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ **Date** _____

Signature of Patient/Guardian

CONFIDENTIAL