MEDICAL HISTORY

Name_____

Do you consider yourself to be in good health? YES NO

Are you now or have you been under a physician's care within the past year? YES NO

If Yes, specify condition being treated_____

Do you take any medications YES NO

Please specify name and purpose of medications:_____

_____

_____

_____

Do you have or have you ever had high blood pressure? YES NO

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? YES NO

Do you have or have you ever had any heart or blood problems? YES NO

Do you bleed or bruise easily? YES NO

Have you ever been diagnosed as being HIV positive or having AIDS? YES NO

Have you ever had hepatitis or liver disease? YES NO

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:_____

Are you now in pain? YES NO

Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other_____

Do you have any other allergies? YES NO

If yes, please describe:_____

Have you ever had any severe reaction to dental treatment or local anesthetics? YES NO

Have you ever received counseling for use of alcohol and/or prescription drugs? YES NO

How long ago did you last see a dentist?_____

Who was your previous dentist?_____

Do you think your teeth are affecting your general health in any way? YES NO

Do you have or have you ever had bleeding or sensitive gums? YES NO

Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO

Have you ever used or are you now using tobacco or alcohol? YES NO

Have you ever taken Fosamax, Actonel, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? YES NO

Women: Are you pregnant? YES NO

Are you taking birth control pills? 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)

I authorize Dr. Clayton M. Hansen and/or such associates as 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; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of 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 on 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-rays 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. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing of 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 preventive and operative treatment procedures in hops 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.

Signature:_____ Date_____

(Patient, legal guardian or authorized agent of parent)

Witness:_____ Date_____