1. Are you having pain or discomfort at this time? ..... Yes No

2. Have you been a patient in the hospital during the past two years? ..... Yes No

3. Have you been under the care of a medical doctor during the past two years? ..... Yes No

Physician's Name_____ Phone No. _____

4. Have you taken any medication or drugs during the past two years? ..... Yes No

5. Are you now taking any medication, drugs or pills? ..... Yes No

If yes, please list: _____

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? …… Yes No

If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure.....	YES NO	Artificial Joints (hip, knee, etc.)..	YES NO	Hepatitis A/B/C/D.....	YES NO
Heart Disease or Attack.....	YES NO	Kidney Trouble….....	YES NO	Venereal Disease.....	YES NO
Angina Pectoris.....	YES NO	Ulcers ……....	YES NO	A.I.D.S.....	YES NO
Congenital Heart Disease.....	YES NO	Diabetes ..(Type I) ..(Type II).....	YES NO	H.I.V. Positive.....	YES NO
Heart Murmur.....	YES NO	Thyroid Problems.....	YES NO	Cold Sores/Fever Blisters.....	YES NO
High Blood Pressure….....	YES NO	Glaucoma……....	YES NO	Blood Transfusion.....	YES NO
Arteriosclerosis.....	YES NO	Cosmetic Surgery.....	YES NO	Hemophilia.....	YES NO
Mitral Valve Prolapse.....	YES NO	Emphysema.....	YES NO	Anemia.....	YES NO
Artificial Heart Valve.....	YES NO	Chronic Cough.....	YES NO	Sickle Cell Disease.....	YES NO
Heart Pacemaker.....	YES NO	Tuberculosis.....	YES NO	Bruise Easily.....	YES NO
Heart Surgery……..	YES NO	Asthma.....	YES NO	Liver Disease.....	YES NO
Rheumatic/Scarlet Fever	YES NO	Hay Fever.....	YES NO	Yellow Jaundice.....	YES NO
Arthritis.....	YES NO	Allergies or Hives.....	YES NO	Epilepsy or Seizures….....	YES NO
Rheumatism……	YES NO	Sinus Troubles.....	YES NO	Fainting or Dizzy Spells.....	YES NO
Cortisone Medicine.....	YES NO	Radiation Therapy.....	YES NO	Nervousness……....	YES NO
Drug Addiction.....	YES NO	Chemotherapy……....	YES NO	Psychiatric Treatment.....	YES NO
Stroke.....	YES NO	Organ Transplant-Implant……	YES NO	Developmentally Disabled.....	YES NO
Sleep Apnea……..……	YES NO	Chicken Pox-Shingles……	YES NO	Diphtheria……	YES NO
				Smoke……	YES NO

8. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?…… Yes No

9. Do your ankles swell during the day? …… Yes No

10. Do you use more than two pillows to sleep? ..... Yes No

11. Have you lost or gained more than 10 pounds in the past year? …… Yes No

12. Do you ever wake up from sleep and feel short of breath? …… Yes No

13. Are you on a special diet? …… Yes No

14. Has your medical doctor ever said you have a cancer or tumor? …… Yes No

15. Do you have or have you had any disease, condition, or problem not listed? …… Yes No

If yes, please list: _____

Woman Only: Are you pregnant? Yes, what month? _____ No Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. **Parent Signature** _____ **Date** _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (**name of patient**) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. Canada's anti-spam legislation requires that we obtain your consent to continue sending you electronic communications. By signing down below, you are authorizing Dentistry in Aurora to continue communicating with you electronically.

4. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ **Date** _____ **Witness** _____

Parent or Responsible Party _____ **Relationship to Patient** _____