HORIZON DENTAL GROUP

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MEDICAL INFORMATION

Patient Name: _____ Date: _____

1. Are you having pain or discomfort at this time? _____
2. Have you been a patient in the hospital during the past two years? _____
3. Have you been under the care of a medical doctor during the past two years? _____

   Physician's Name: _____

   Reason: _____
4. Are you now taking any medications or drugs? _____

   If yes, please list: _____
5. Are you sensitive or allergic to any medication or anesthetics? _____

   If yes, please list: _____
6. Indicate which of the following you have had or have at present. Circle YES or NO to each item.

Heart Disease or Heart Attack	YES NO	Emphysema	YES NO
Heart Murmur	YES NO	Tuberculosis	YES NO
High Blood Pressure	YES NO	Asthma	YES NO
Mitral Valve Prolapse	YES NO	Allergies or Hives	YES NO
Artificial Heart Valve	YES NO	Sinus Trouble	YES NO
Heart Pacemaker	YES NO	Hepatitis	YES NO
Rheumatic Fever	YES NO	Venereal Disease	YES NO
Drug Addiction	YES NO	HIV Positive or AIDS	YES NO
Stroke	YES NO	Anemia	YES NO
Artificial Joints	YES NO	Liver Disease	YES NO
Kidney Trouble	YES NO	Epilepsy or Seizures	YES NO
Diabetes	YES NO	Fainting or Dizzy Spells	YES NO
Cancer	YES NO	Anxiety	YES NO
Latex Allergy	YES NO	Tobacco Use	YES NO
		Alcohol Use	YES NO

7. Do you have or have you had any disease, condition, or problem not listed? _____

   If yes, please list _____

DENTAL INFORMATION

Do your gums bleed when you brush?	YES NO	Do you snore?	YES NO
Are your teeth sensitive to heat or cold?	YES NO	Do you get a lot of cold sores?	YES NO
Are your teeth sensitive to chewing?	YES NO	Do you combat bad breath?	YES NO
Do you grind or clench your teeth?	YES NO	Do you play contact sports?	YES NO
Do you bleed or bruise easily?	YES NO	Do you have frequent headaches?	YES NO
Do you have any fear of dental work?	YES NO	Are you subject to fainting?	YES NO

Date of last dental examination: _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Have you ever had orthodontic braces? _____

OVER

CONSENT TO PROCEED

I authorize Dr._____ and/or such associates or assistants as he/she 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. 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. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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. I 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 by 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 a bronchoscope 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 of Patient, Legal Guardian, or Authorized Agent of Patient Date

_____

Witness Date