Patient Information

Patient Name _____ Male○ Female○ Birthdate_____

Name of Parent or Guardian (if applicable): Mother _____ Father_____

Address _____ City _____ Postal Code _____

Telephone: Home _____ Business (M)_____ (F)_____ Cell_____

Physician _____ Telephone _____Dentist _____Telephone _____

Medical History

		YES	NO
1.	Do you consider yourself to be in good health?	○	○
2.	Are you presently under the care of a physician?	○	○
3.	Are you presently taking any medicines or drugs?	○	○
	If Yes, please specify _____		
4.	Have you ever been hospitalized, or had a serious illness?	○	○
5.	Do you bleed abnormally?	○	○
6.	Do you bruise easily?	○	○
7.	Do you heal easily and normally?	○	○
8.	Do you suffer from frequent headaches?	○	○
9.	Do you have any ear problems?	○	○
10.	Do you have frequent sinus trouble or nasal congestion?	○	○
11.	Do you get frequent colds or sore throats?	○	○
12.	*FEMALES ONLY*: Are you taking birth control pills?	○	○
	Are you pregnant?	○	○
	If yes, at what stage of pregnancy? _____		
13.	Do you have any allergies?	○	○

If yes, please specify:

○ aspirin ○ local anaesthetics
○ foods ○ penicillin
○ other_____

14. Have you ever had, or been treated for any of the following:

○ heart trouble	○ tuberculosis	○ anemia/blood disease	○ cancer
○ rheumatic fever	○ HIV/AIDS	○ mononucleosis	○ growth or tumor
○ heart murmur	○ blood transfusion	○ injury to face/jaws	○ thyroid disease
○ diabetes	○ epilepsy	○ abnormal blood pressure	○ IV drug use
○ asthma	○ mental disease	○ arthritis	○ hepatitis
○ sexually transmitted disease		○ persistent diarrhea	○ persistent skin rash

15. If you have any disease, problem, or condition not listed above, please specify:

_____

Patient/Parental Consent

I, _____ (patient/parent or guardian) for _____
hereby confirm that, to the best of my knowledge, the above information is accurate and correct, and do hereby authorize the performance of required dental services by Dr. Darren Tkach and staff. I further authorize the administration of whatever method of treatment and medication as are deemed necessary by Dr. Tkach. I accept full responsibility for all financial arrangements. As the patient is a minor, I hereby sign on his/her behalf as legal guardian.

_____ _____

Parent or Guardian Signature Relationship to patient

Witness

Date