HEALTH HISTORY

Name_____
Are you currently in pain? Explain:_____
Are you in good health? If no, explain:_____
Doctors Name:_____
Do you have an existing illness? Explain:_____
Have you been hospitalized in the past two years? If yes, explain:_____
Do you bleed excessively when cut?_____
Are you taking any medication, pills or drugs? If so please list:_____
_____

Do you have, or have you had any of the following? If so describe under remarks.

	Yes	No		Yes	No
Heart Disease	□	□	Radiation Treatment	□	□
Artificial Valve	□	□	Liver Disease	□	□
High Blood Pressure	□	□	Kidney Disease	□	□
Blood Disease	□	□	Hepatitis	□	□
Heart Murmur	□	□	Asthma	□	□
Diabetes	□	□	Tuberculosis	□	□
Rheumatic Fever	□	□	Aids or HIV Positive	□	□
Stroke	□	□	Allergy to:		
Epilepsy	□	□	Penicillin	□	□
Arthritis	□	□	Anesthetic	□	□
Tumor History	□	□	Other	□	□
VD	□	□	Are you Pregnant?	□	□
Artificial Joint	□	□	Nursing?	□	□

Do you have any present dental complaints?_____
If you could change one thing with your smile, what would it be?_____
If there were a simple, inexpensive way to whiten your teeth, would you be interested?_____
When was your last full mouth x-rays taken?_____ When was your last cleaning?_____
Remarks:_____
_____

Health questionnaire acknowledgement and consent to proceed. I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Lee and/or such associates or assistants 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, 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 do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative 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 understand that placement of fillings may render the involved sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.

_____ Date:_____
Signature (of patient, legal guardian, or authorized agent of patient)

_____
Dr. Todd P. Lee, DDS