



PATIENT LABEL

ALLERGIES: \_\_\_\_\_

DENTAL HEALTH HISTORY: Please check the box for any condition that applies to the patient, currently or a history of. Your answers are always confidential.

Do you/your child have currently, or history of the following: \_\_\_ None

Table with 4 columns: Heart conditions, Lung Problems, Neurological Issues, Stem cell or Organ Transplant, Asthma, Stroke, Heart Surgery/ Transplant, Shortness of Breath, Syncope (Fainted), Valve Replacement, STD's (list type), Epilepsy (Seizures), High/Low Blood Pressure, Tuberculosis, Mental Issues, Rheumatic Fever, Allergies (list type), Diabetes, Anemia, Skin Rash, Immunodeficiencies Inherited or Acquired, Bleeding or Platelet Disorders, Sickle Cell Anemia, Kidney Disfunction, Blood Transfusion, Liver conditions, Autoimmune disease, Thyroid Problems, Hepatitis (list type), Joint Replacement with complications, Cancer ie. Chemo, Radiation ect., Painful/Swollen Joints, HIV/AIDS Controlled or uncontrolled

If yes, please explain:

How many times have you been pregnant? Are you pregnant now? Yes / No

Please list your primary care provider:

Have you been hospitalized in the past two (2) years? Yes / No

If yes, list date(s) & reason(s):

Current Medications:

Have you ever had an allergic or adverse reaction to local anesthetic (lidocaine, novocaine)? Yes / No

If yes, list the date & type of reaction:

Have you ever had an allergic or adverse reaction to antibiotics (penicillin, sulfa, etc.) Yes / No

If yes, list the date & type of reaction:

Please list any current dental issues:

Additional Concerns:

I certify that I have read & understand the above questions, answered the questions completely, and to the best of my knowledge. Please allow my signature below to acknowledge that FDOH-Putnam and staff will not be held liable for any medical history I may have left out on this form. I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment, explained to my satisfaction.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(if patient is a child, parent or legal guardian must sign)

Dental Staff Sign (witness): \_\_\_\_\_ Date: \_\_\_\_\_

Form must be updated annually & REVIEWED each visit & if no changes, have patient sign below.

\_\_\_\_\_ Date: \_\_\_\_\_ (must be <1yr from initial visit)
(Dental Staff Must Sign as Reviewed)

\_\_\_\_\_ Date: \_\_\_\_\_ (must be <1yr from initial visit)
(Dental Staff Must Sign as Reviewed)