Goodheart Dental

Name: _____
DOB: _____
Email: _____
Emergency Contact:_____ Phone #:_____ Relation: _____

Medical History

Do you have or have you ever had?
- ◯ Acid Reflux
- ◯ Artificial Joints
- ◯ Asthma
- ◯ Cancer
- ◯ Cold Sores
- ◯ Diabetes

*__If Diabetic__:
Last A1C: ___
Date of last eye exam:
_____

- ◯ Dry Mouth
- ◯ Epilepsy/Seizures
- ◯ Glaucoma
- ◯ Heart Problems
- ◯ High Blood Pressure
- ◯ Kidney Problems
- ◯ Liver Problems
- ◯ Seasonal Allergies
- ◯ Sleep Apnea
- ◯ Stroke
- ◯ Thyroid Problem
- ◯ Tuberculosis

Are you allergic to?
- ◯ Aspirin
- ◯ Codeine
- ◯ Penicillin
- ◯ Sulfa
- ◯ Other _____

Do you Smoke/Vape/Chew Tobacco? Y or N

Female Patients: Are you pregnant? Y or N
If yes, what is your due date?
_____

Are you having any current medical treatment or investigation? Y or N
If yes, please explain:
_____
_____
_____
_____
_____
_____
_____

Please explain any surgeries or hospitalizations:
_____
_____
_____
_____
_____
_____

List any medications (or provide a list) you are currently taking including vitamins/herbal:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary and advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.
Payment for all treatment and services rendered are my responsibility.

_____ _____
Patient's Signature Date
If patient is a child or requires a guardian:

_____ _____
Guardian/Parent Signature Date