Goodheart Dental

Name: _____ DOB: _____ Email: _____

Emergency Contact: _____ Phone: _____ Relation: _____

_____OTHER INFORMATION_____

What is the reason for today's visit? _____
How did you hear about us? Referred by? _____
Do you have any questions or concerns we can help you with today? _____
When was your last dental cleaning? _____
How nervous are you regarding dental treatment? *Not at all / a little / quite / very / extremely*
Is there any reason why you cannot recline fully in the dental chair? _____

_____MEDICAL INFORMATION_____

Do you have or have you ever had?

- O Acid Reflux
- O Artificial Joints
- O Asthma
- O Cancer
- O Cold Sores
- O Diabetes
  ***If Diabetic:**
  Last A1C _____
  Date of last eye exam
  _____
- O Dry Mouth
- O Epilepsy/Seizures
- O Glaucoma
- O Heart Problems
- O High Blood Pressure
- O Kidney Problems
- O Liver Problems
- O Seasonal Allergies
- O Sleep Apnea
- O Stroke
- O Thyroid Problem
- O Tuberculosis

Are you allergic to?

- O Asprin
- O Codeine
- O Latex
- O Penicillin
- O Sulfa
- O 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/herbals:
_____
_____
_____
_____
_____
_____

Is there any other aspect of your health or history that you feel we should be aware of?
_____
_____
_____

_____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:

_____ _____
Parent/Guardian Signature Date