DRS ENSOR JOHNSON & LEWIS

Cosmetic and General Dentistry

Date:_____

Name:_____Date of Birth:_____Sex:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Address:_____City/State/Zip:_____

S.S. #:_____Occupation:_____Email:_____

Physician:_____

Since dental problems can be produced by a combination of many complex elements, it is important to understand and resolve every possible contributing factor. Though some of the following questions may seem to be unrelated to your current condition, they are all consistent with the proper management of your oral health, and will be treated confidentially.

Please check if you have any of the following diseases or health problems, and when first discovered:

___ Rheumatic Fever
___ Heart Murmur
___ Mitral Valve Prolapse
___ Swollen Ankles
___ High or Low Blood Pressure
___ Pain in Chest
___ Shortness of Breath
___ Arthritis
___ Thyroid Trouble
___ Blood Disorders
___ Herpes or Cold Sores
___ Heart Disease or Heart Attack

___Asthma or Hay Fever
___ Allergy
___ Hives or Skin Rash
___ Coughing up Blood
___ Sinus Trouble
___ Anemia
___ Fainting Spells or Seizures
___ Stroke
___ Liver Disease
___ Convulsions
___ Epilepsy
___ Psychiatric Therapy

___ Growth or Tumors
___ Cancer
___ Kidney Trouble
___ Stomach Ulcers
___ Hepatitis or Jaundice
___ Diabetes
___ Venereal Disease
___ Tuberculosis
___ Alcoholism
___ Ulcers
___ HIV, AIDS
___ Other

Please list any medications you are currently taking:

_____

Please list all past surgeries:

_____

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Please check if you are allergic or have an unusual reaction to:

___ Local Anesthetics (Novocaine, Xylocaine, etc.)
___ Latex
___ General Anesthetics (Pentothal, Gas, etc.)
___ Penicillin or Sulfa Drugs
___ Other (please describe below)

___ Aspirin
___ Barbituates, Sedatives, Sleeping Pills
___ Metals
___ Codeine, Demerol or other Narcotics

_____

_____

Please circle Yes or No to the following questions:

Has there been any change in your general health in the past year?	Yes No
Are you now under the care of a medical doctor?	Yes No
Have you been hospitalized or been treated for a serious illness in the past five (5) years?	Yes No
Do you get short of breath when lying down, or do you need extra pillows when sleeping?	Yes No
Have you had abdominal bleeding with previous dental extractions or surgery?	Yes No
Have you had surgery or radiation treatment for a growth on your face or mouth?	Yes No
Have you ever had any serious trouble during dental treatment?	Yes No
Do you smoke or use smokeless tobacco?	Yes No
Are you pregnant?	Yes No
Do you take birth control pills?	Yes No

Emergency Contact:_____Relationship:_____Phone:_____

APPOINTMENTS: Once an appointment has been made, please remember this time has been reserved especially for you. If you miss your appointment without proper notification, a $50 charge will be assessed. To avoid this charge, please call the office to reschedule your appointment at least 48 hours in advance.

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears above, to administer any treatment agreed upon; or to administer local anesthetics, agents or drugs; to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signature:_____Date:_____

Authorization must be signed by the patient, or the nearest relative in the case of a minor, or when the patient is physically or mentally incompetent.