DESERTDENTAL

Ryan M. Wieseler, D.D.S.

NAME: ______________________________ TODAY'S DATE: ______________________

PATIENT MEDICAL HISTORY — ADULT

Medical Doctor ______________________ Office Phone ______________ Date of Last Exam ____________

Address ____________________________________ Preferred Pharmacy ______________________

1. Do you have or have you had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
High Blood Pressure	❐	❐	Heart Murmur	❐	❐	Easily Winded	❐	❐
Heart Attack	❐	❐	Angina	❐	❐	Stroke	❐	❐
Rheumatic Fever	❐	❐	Frequently Tired	❐	❐	Hay Fever/ Allergies/ Asthma	❐	❐
Swollen Ankles	❐	❐	Anemia	❐	❐	Turberculosis	❐	❐
Fainting/ Seizures	❐	❐	Emphysema	❐	❐	Radiation Therapy	❐	❐
Low Blood Pressure	❐	❐	Cancer	❐	❐	Glaucoma	❐	❐
Epilepsy/ Convulsions	❐	❐	Arthritis	❐	❐	Recent Weight Loss	❐	❐
Diabetes	❐	❐	Joint Replacement or Implant	❐	❐	Liver Disease	❐	❐
Kidney Diseases	❐	❐	Hepatitis/ Jaundice	❐	❐	Heart Valve	❐	❐
AIDS or HIV Infection	❐	❐	Sexually Transmitted Disease	❐	❐	Respiratory Problems	❐	❐
Thyroid Problem	❐	❐	Stomach Troubles/ Ulcers	❐	❐	Mitral Valve Prolapse	❐	❐
Heart Disease	❐	❐	Chest Pains	❐	❐	Other ______________	❐	❐
Cardiac Pacemaker	❐	❐	Bisphosphonate (Fosamax)	❐	❐			

Question	Yes	No
2. Have you ever been told by your physician that you require premedication before any dental treatment?	❐	❐
3. Are you under medical treatment now?	❐	❐
4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❐	❐

If yes, please explain ______________________________

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Question	Yes	No
5. Are you taking any medication(s) including nonprescription medicine?	❐	❐

If yes, what medication(s) are you taking? ______________

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Question	Yes	No
6. Do you use tobacco?	❐	❐
7. Do you use controlled substances?	❐	❐
8. Are you wearing contact lenses?	❐	❐

ALLERGIES

9. Are you allergic to or have you had any reactions to the following?

Item	Yes	No
Local Anesthetics (e.g. novocaine)	❐	❐
Penicillin or any other Antibiotics	❐	❐
Sulfa Drugs	❐	❐
Barbiturates	❐	❐
Sedatives	❐	❐
Iodine	❐	❐
Aspirin	❐	❐
Any Metals (e.g. nickel, mercury, etc.)	❐	❐
Latex Rubber	❐	❐
Other (please list) ______________	❐	❐

10. ***Women Only:***

Question	Yes	No
a) Are you pregnant or think you may be pregnant?	❐	❐
b) Are you nursing?	❐	❐
c) Are you taking oral contraceptives?	❐	❐

MISSED AND LATE / CANCELLED APPOINTMENT POLICY

24 business hours cancellation notice required. At the second failed or late/cancelled appointment, a fee of $50 will be billed. A third failed or late/cancelled appointment may result in dismissal from our practice.

AUTHORIZATION AND RELEASE

I hereby authorize and request the performance of dental services for myself and give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.

I realize radiographs and clinical photographs are used for diagnostic and treatment planning purposes. They may also be used as educational and teaching aids. I authorize the use of radiographs and photographs for these purposes.

I understand and acknowledge that I am financially responsible for the services provided regardless of insurance coverage. I further understand that a 1% finance charge (12% annually) will be added to any balance over 60 days. Returned checks will be assessed a fee of $25.00. I have read and understand the missed and late/cancelled appointment policy.

To the best of my knowledge, the above answers are true and correct. If ever I have a change in my health or medications, I will inform the dentist at my next appointment.

Signed ____ Date ______________

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