PATIENT INFORMATION

Mrs./Ms./Mr./Dr. (Please circle one)
Name: _____Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____ Sex: M / F Birth Date: ____ /____ /_____

Parent/Guardian/POA/Spouse Name and Relationship: _____

Email: _____ Phone Number: _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Whom may we thank for referring you to our practice? _____

Party responsible for this account: _____

RELEASE AND ASSIGNMENT

- I understand that a release of information, to include any records of any treatments or examinations rendered, may be required to facilitate the diagnosis to a referring dentist. It is the patient's responsibility to contact the referring dentist if deemed necessary by the RDHAP.

- Patients are always responsible for full payment of their bill at the time of services. **Cancellations less than 24 hours from scheduled appointment time will be charged a fee equal to 50% of planned services.**

_____ _____

Signature of Patient, POA, or Parent/Guardian. **Date**

CONSENT FOR PROFESSIONAL SERVICES

I hereby authorize and request Cynthia G. MacDougall, RDHAP, to administer any treatment, topical anesthetics, and localized antibiotics to perform such dental hygiene procedures as may be deemed necessary in the diagnosis and treatment of my case after discussion of the proposed treatment, alternatives, and implications. I understand that results are not guaranteed or warranted and cannot be guaranteed or warranted.

_____ _____

Signature of Patient, POA, or Parent/Guardian. **Date**

Patients Name: _____ DOB_____

Patient's Confidential Medical Health History - (Check all that apply)

Have you ever had any of the following? ☐Cancer or Tumor ☐Heart Ailment / Angina ☐Heart Murmur / Defect ☐Mitral Valve Prolapse ☐Rheumatic Fever ☐Rheumatic Heart Disease ☐History of Bacterial Endocarditis ☐Artificial Joints ☐Artificial Heart Valve ☐High / Low Blood Pressure ☐Pacemaker ☐Tuberculosis / Lung Problems ☐Kidney Disease ☐Hepatitis / Liver Disease ☐Alcoholism ☐Blood Transfusion ☐Diabetes ☐Neurological condition ☐Epilepsy, Seizures, Fainting Spells ☐Emotional Condition ☐Arthritis ☐Herpes or Cold Sores	☐AIDS or HIV Positive ☐Migraines / Frequent Headaches ☐Anemia / Blood Disorders ☐Abnormal Bleeding after Surgery ☐Hay fever or Sinus Trouble ☐Allergies or Hives ☐Asthma ☐Other not listed above _____ _____ **Are you allergic to, or have an adverse reaction to any of the following?** ☐Latex Material ☐Penicillin / Other Antibiotics ☐Local Anesthesia / Novocain ☐Codeine or other Narcotics ☐Sulfa Drugs ☐Barbiturates / Sedatives ☐Sleeping Pills ☐Aspirin	☐**Other Allergies**: _____ _____ **Do you or have you used**: ☐Cigarettes / Chewing Tobacco **Are you taking any of the following?** ☐Aspirin ☐Anticoagulants (Blood Thinners) ☐Antibiotics / Sulfa Drugs ☐High Blood Pressure Medicine ☐Antidepressants / Tranquilizers ☐Insulin / Orinase ☐Other Diabetes Drugs ☐Nitroglycerin ☐Cortisone / Other Steroids ☐Osteoporosis (bone density) medicine ☐Other (See table below)

Please list any other Medications not listed above

Medications	Dose	Reason for Taking Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Are you being treated by a physician now? ☐Yes.☐No. If YES explain:
  _____

- WOMEN ONLY (Please circle Yes or No for each)

☐Yes. ☐No. Are you or could you be pregnant? If Yes, what month?_____
☐Yes. ☐No. Are you nursing?

- Have you had problems with prior dental treatment? ☐Yes. ☐No. Is yes explain:_____
- Date of last dental exam: _____ Have you ever been pre-medicated for dental treatment? ☐Yes. ☐No.

- Do you have or have you had any other disease or medical problems **NOT** listed on this form? If YES, please explain:

_____

- Is there any issue or condition you would like to discuss with the Hygienist in private ☐Yes. ☐No.

Cynthia G. MacDougall, RDHAP | Hermosa Beach CA, 90254 | 310.897.4787

The practice of dental hygiene involves treating the whole person. If the RDHAP determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental hygiene treatment.

I authorize the RDHAP to contact my dentist or physician

_____ _____

Signature of Patient, POA, or Parent/Guardian **Date**

Physician's Name and Phone Number: _____

Dentist's Name Phone Number:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my RDHAP of any change in my health and/or medication. Further, I will not hold my RHDAP, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient, POA, or Parent/Guardian **Date** **Signature of RDHAP** **Date**

Medical Updates

I reviewed my medical history and confirm that it accurately states past and present conditions

Date	Signature	Change to Health History	Staff's Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____