Michael Green DDS, 2821 Eastern Ave., Suite #5, Sacramento, CA 95821

NAME ____

Circle

YES NO 1. Are you having pain or discomfort at this time?
YES NO 2. Do you feel very nervous about having dental treatment?
YES NO 3. Have you ever had a bad experience in the dental office?
YES NO 4. Have you been a patient in the hospital during the past two years?
YES NO 5. Have you been under the care of a medical doctor during the past two years?

Physician's Name ____

Address ____________________________ Phone # ________________

YES NO 6. Have you taken any medicine or drugs during the past two years?
YES NO 7. Are you now taking any medication, drugs or pills?

If yes, please list: ____

YES NO 8. Are you allergic to have you reacted adversely to any of the following medications?

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocain or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)

YES NO 9. Are you aware of being allergic to any other medications or substance?
If yes, please list: ____

10. Circle any of the following which you have had or have at present

Y N Heart Failure	Y N Kidney Trouble	Y N Arthritis	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Heart Disease or Attack	Y N Ulcers	Y N Rheumatism	
Y N Angina Pectoris	Y N Cosmetic Surgery	Y N Cortisone Medicine	Y N Cold Sores Fever Blisters
Y N High Blood Pressure	Y N Emphysema	Y N Glaucoma	Y N Epilepsy or Seizures
Y N Heart Murmur	Y N Cough	Y N Pain in Jaw Joints	Y N Fainting or Dizzy Spells
Y N Rheumatic Fever	Y N Tuberculosis(TB)	Y N A.I.D.S.	Y N Nervousness
Y N Congenital Heart Lesions	Y N Asthma	Y N Hepatitis A(infectious)	Y N Psychiatric Treatment
	Y N Scarlet Fever	Y N Bisphosphonates	Y N Are you allergic to any metals (i.e.nickle?)
Y N Sickle Cell Disease	Y N Hepatitis B(serum)	Y N Liver Disease	
Y N Artificial Heart Valve	Y N Sinus Trouble	Y N Bruise Easily	Y N Have you had a skin reaction to any kind of jewelry?
Y N Heart Pacemaker	Y N Allergies or Hives	Y N Yellow Jaundice	
Y N Heart Surgery	Y N Diabetes	Y N Blood Transfusion	
Y N Artificial Joints (Hip,Knee)	Y N Thyroid Disease	Y N Drug Addiction	Y N Latex Gloves Allergy
Y N Mitro Valve Prolapse	Y N X-ray/Cobalt Treatment	Y N Hemophilia	
Y N Stroke	Y N Chemotherapy Y N Anemia		

YES NO 11. Has your medical doctor ever said you have a cancer or tumor?
YES NO 12. Do you have any disease, condition, or problem not listed?

FOR WOMEN ONLY:

Are you pregnant? ___Yes ___No If yes, what month?_____Are you taking birth control pills? ___Yes ___ No

ABOVE INFORMATION IS TRUE

Patient Signature/Parent or Guardian ____________________________ Date ___/____/_______

Patient Name Printed ______________________________ Date ___/____/_______

CONSENT:

The undersigned hereby authorized Doctor to take X-ray, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) ____
And further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 %finance charge (21%annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient____________________________Date_______Witness________________________

Parent or Responsible Party____Relationship to Patient________