Southern Arizona Periodontics, P.L.C.

Susan B. Sharp, D.D.S.

MEDICAL HISTORY

PATIENT'S NAME	EXAMINING DOCTOR

Name of Medical Doctor	Phone Number	Date of Last Medical Exam

Are you allergic to or have experienced any ill effects from:

☐ PENICILLIN	☐ CODEINE	☐ ASPIRIN	☐ NITROUS OXIDE
☐ TETRACYCLINE	☐ PERCOCET	☐ IBUPROFEN	☐ LATEX
☐ ERYTHROMYCIN	☐ DEMEROL	☐ XYLOCAINE	☐ OTHER
☐ OTHER ANTIBIOTICS	☐ VALIUM	☐ CARBOCAINE	☐ NO KNOWN ALLERGIES

Have you ever had any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Disease or Attack	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Epilepsy or Seizures
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Fainting
☐	☐	Heart Pacemaker	☐	☐	Ulcers	☐	☐	Thyroid Disease	☐	☐	Nervous Problems
☐	☐	Angina Pectoris	☐	☐	Anorexia / Bulimia	☐	☐	Kidney Disease	☐	☐	Mental Illness
☐	☐	Stroke	☐	☐	Alcoholism	☐	☐	Hepatitis A (infectious)	☐	☐	Psychiatric Treatment
☐	☐	Mitral Valve Prolapse	☐	☐	Drug Addiction	☐	☐	Hepatitis B (serum)	☐	☐	Convulsions
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Hepatitis C	☐	☐	Artificial Joints (hip, knee)
☐	☐	Circulatory Problems	☐	☐	Chemo - Radiation	☐	☐	Rheumatic Fever	☐	☐	PREMED NECESSARY
☐	☐	Emphysema	☐	☐	Malignancies - Cancer	☐	☐	Venereal Disease	☐	☐	Phen-fen/Redux Usage
☐	☐	Respiratory Problems	☐	☐	Abnormal Bleeding	☐	☐	HIV Positive	Other Health Concerns:		
☐	☐	Sinus Problems	☐	☐	Hemophilia	☐	☐	AIDS			

What medications or drugs are you taking at this time?

Are you a smoker? ☐ NO ☐ YES: ***How Many?*** _____

Females: Are you pregnant or trying to become pregnant? ☐ NO ☐ YES: ***How Many Months?*** _____

Medical history reviewed by Dr. _____ ***Date*** _____

DENTAL HISTORY

What is your immediate problem?

Have you ever had periodontal treatment? ***When:***

What is your maintenance cleaning schedule? ***When was your last cleaning?***

CONSENT

SOUTHERN ARIZONA PERIODONTICS, P.L.C. recognizes that every patient has the Right of Privacy concerning their personal dental health information. I confirm that I have read a copy of the Notice of Privacy Practices and understand my rights.

X Signed: ***Date***

AUTHORIZATION TO PAY BENEFITS TO DENTISTS: I hereby authorize payment directly to the Dentist of the Surgical and or Dental Benefits, if any, otherwise payable to me for the services as described but not to exceed the reasonable and customary for those services. I understand I am financially responsible for charges not covered by this authoriz
default I agree to pay together with such collection costs and responsible attorney's fees as may be required.

X Signed: ***Date***

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the 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 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. In the event of default I (We) promise topay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

X Patient: ***Date*** ***Witness***

X Parent or Responsible Party ***Relationship to Patient***

UPDATES

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____