HOUSTON ORAL HEALTHCARE SPECIALISTS

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Patient's Name _____ **DOB** _____

For Staff use Only
BP: **Ht:**
P: **Wt:**
O2:
Pre-medication _____

Medical History:
Check all the conditions that apply to you:

- ❑ Anemia/Blood Disease
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Control Pills
- ❑ **Bisphosphonates**
- ❑ Blood Pressure/High
- ❑ Blood Pressure/Low
- ❑ Blood Thinners (ASA, Plavix, Coumadin)
- ❑ Cancer
- ❑ Chemotherapy
- ❑ **Diabetes I II**
- ❑ Epilepsy/Seizures
- ❑ Chemical Dependency
- ❑ **Hemophilia/Bleeding Disorder**
- ❑ Fainting/Nervous
- ❑ Glaucoma
- ❑ **Heart Trouble**
- ❑ Pacemaker
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Herpes Virus/Cold Sores
- ❑ HBV Positive
- ❑ HCV Positive
- ❑ HIV Positive
- ❑ **Artificial Joint Replacement** (Pins/Rods)
- ❑ Kidney Disorder
- ❑ Mental Health Condition
- ❑ Migraine Headache
- ❑ **Mitral Valve Prolapse**
- ❑ Neck/Head Pain
- ❑ Pregnant
- ❑ **Rheumatic Fever**
- ❑ **Heart Murmur**
- ❑ Stroke
- ❑ Thyroid
- ❑ Transplant
- ❑ Tuberculosis
- ❑ Lung Disease
- ❑ TMJ/Clicking Joint
- ❑ Venereal Disease
- ❑ Sinus Condition
- ❑ **Cardiovascular Disease** (MI, angina, stents, shunts, valve)

Are you allergic to:
- ❑ Aspirin
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sedative/Tranquilizer
- ❑ Sulfa
- ❑ Other _____

Height:_____
Weight:_____

Are you being treated by a Physician? Yes No If yes, explain:_____
My Primary medical Physician is:_____ Phone _____
Current Medications:_____
_____

Dental History:
Reason for today's visit:_____ Last dental visit:_____

Are you experiencing:
- ❑ Pain Location:_____
- ❑ Sensitivity of teeth Location:_____
- ❑ Bleeding of gums Location:_____
- ❑ Swelling Location:_____

In case of emergency contact:_____ Phone_____

Authority to Treat

I give Houston Oral Healthcare Specialists authority to administer dental x-rays, local injections, anesthetics and, if requested, nitrous oxide or a tranquilizer in the subsequent treatment of my case. If I have a medical condition such as a heart murmur that requires premedication, I acknowledge that **it is my responsibility to inform and remind the doctor, assistant or hygienist at the beginning of each visit.**

PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY BALANCE THAT IS NOT PAID BY YOUR INSURANCE COMPANY

The above information is true and complete to the best of my knowledge. I agree to pay my copayment at the time services are rendered. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date