Patient Information Form

Name_____ Mailing Address _____

Cell Phone _____ Work _____ Home _____ Zip _____

Social Security # _____ How did you find us? _____

Email _____ M / F _____ Birthdate _____

Financially Responsible Party _____ Employer_____

Dental Insurance Company and ID#_____

Medical History:

Please list medications:_____
Physician's Name_____
Do you have any drug allergies? Y N List_____

Circle past or present conditions that apply to you:

Blood Thinner Including Aspirin, Excessive Bleeding, Anemia, Heart Valve Replacements, Heart Infection, Heart Murmer, Heart Problems, Heart Attack, Arthritis, Diabetes, Cancer, HIV, TB, Hepatitis, Addiction, Epilepsy, VD, Stroke, Asthma, Thyroid Disease, Mental Health Issues, History of Fosamax, Actonel, Boniva, Artificial Joints, Birth Control.

Any medical issues not listed:
Have you ever or do you currently use tobacco? Y N Type _____
Are you pregnant? Y N
Has anyone recommend you take a premed before dental treatment Y N
Reason for dental visit: _____Emergency Contact_____

Informed Consent to Treat

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Lassiter, Dr. Allen and Dr. Shelton and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time. Root canals may be necessary to treat said nerve problems.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature of patient, legal guardian, or authorized agent of patient: Date: