MILAN DENTAL ASSOCIATES

New Patient Responsibility and Consent Form

Today's Date:_____ Patient Name:_____ _____ ____ ☐Male ☐Female
Last First MI

Date of Birth:_____ Social Security Number:_____

Address:_____
Mailing Address City State Zip

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Email Adress:_____

MEDICAL HISTORY

Physician Name:_____ Phone Number:_____

Are you presently under the care of a physician? _____ Reason:_____

Emergency Contact _____Relationship to Patient_____Phone Number:_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:				Date Occured
Anemia	Yes No	Heart Valve	Yes No	_____
Heart Murmur	Yes No	Heart Condition	Yes No	_____
Ulcers	Yes No	Diabetes	Yes No	_____
Asthma	Yes No	Cancer	Yes No	_____
Epilepsy	Yes No	Pacemaker	Yes No	_____
Abnormal Blood Pressure	Yes No	Artificial Joint	Yes No	_____
Mitral Valve Prolapse	Yes No	Pregnant	Yes No	Due:_____
Rheumatic Fever	Yes No	Taking Birth Control	Yes No	
Have you had a Heart Attack within the last six months			Yes No	_____

Are you currently taking blood thinners? _____ Type?_____

Blood Pressure:_____ Date:_____

HAVE YOU EVER BEEN EXPOSED TO:

Aids Virus	Yes No	Hepatitis	Yes No Type_____
Venereal Disease	Yes No	Tuberculosis	Yes No

Date of your last TB test_____

MEDICATIONS(List all medications you are currently taking)

_____

_____

_____

Pharmacy Name:_____ Phone Number: _____

ALLERGIES

Latex	Yes No	Aspirin	Yes No
Penicillin	Yes No	Dental Anesthetic	Yes No
Codeine	Yes No	Any other Drug?	Yes No

If yes to any other Drug, please list:_____

See Reverse Side

DENTAL HISTORY

Reason for Today's visit_____
Date of last Dental Care_____ Last X-rays_____ Name of Previous Dentist_____
How often do you brush?_____ Floss?_____
Anything we should know about your teeth or previous dental treatment?_____

HAVE YOU HAD PROBLEMS WITH THE FOLLOWING:

Bad Breath	Yes No	Clicking/Popping Jaw	Yes No
Bleeding Gums	Yes No	Periodontal/Gum Problem Treatment	Yes No
Sensitive Hot/Cold	Yes No	Loose/Broken Teeth	Yes No
Sores/Growths in Mouth	Yes No		

CONFIDENTIAL

Do You Use Tobacco? Yes No What Form do You Use?_____
How Much?_____How Long?_____
Do You Currently Use Street Drugs? Sometimes_____ Often_____Never_____
Do You Use Alcohol? Sometimes_____Often_____Never_____

CONSENT FOR TREATMENT AND PAYMENT

I hereby authorize and request the performance of dental services for the above named person. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment.
I also understand that payment in full is expected at the time services are rendered unless prior arrangements are made.

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient/Responsible Party_____Date_____

Dentist Signature_____