

HEALTH INFORMATION

Date of your last dental visit: _____ Reason for this visit: _____

Please check the following health issues that apply to your personal health:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker	Are you currently Pregnant?
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Radiation Therapy	_____ Due Date _____
<input type="checkbox"/> _____	<input type="checkbox"/> Fainting	<input type="checkbox"/> Respiratory Problems	Is snoring or sleep apnea a
<input type="checkbox"/> Anesthesia Allergy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever	problem for you? _____
<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Sinus Problems	Are there any other health
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stomach Problems	issues that we need to be
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stroke	aware of, such as the need
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis	for pre-medication? _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tumors	Please explain:
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> Cholesterol imbalance	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Venereal Disease	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease		_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Mental Disorders	Do you smoke or use other	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mitro-valve prolapse	forms of tobacco? _____	_____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nervous Disorders		_____

- Have you ever had a history of drug dependency? Yes No
- List any and all medications you are currently taking on a regular basis (prescription/over the counter) Please let us know if you are taking Coumadin. _____

- Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

- Are you currently under the care of a physician? Yes No

If yes, please explain: _____

- Name of physician: _____ Phone: _____

To the best of knowledge, all the preceding answers and information provided are true and correct. I understand that if there are any changes to my health history I will inform the doctor and staff at my next appointment without fail.

Signature: _____ Date: _____
Patient, parent or legal guardian

CONSENT FOR SERVICES

I am aware of the following and consent to services provided by this office under the conditions listed below:

- As a condition of this office all services are payable at the time they are rendered, unless arrangements have been made prior to the appointment.
- Fee estimates for dental care prescribed by Dr. Doerfler can only be extended for a period of three months from the date of patient examination.
- A service charge of 1-1/2 % per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.
- I agree to pay the reasonable value of services provided by Dr. Doerfler or his assignee at the time services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of these services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if a suit be instituted hereunder.

Signature of patient, parent, or guardian _____ Date: _____

Relationship to patient: _____