ADULT MEDICAL HISTORY UPDATE

Patient ______________________________________Date__________DOB __________Age____________Sex ☐ F ☐ M

Address_______________________________________City__________________________State______Zip Code_______________

Home Phone___________________Cell Phone________________________Email_______________________________________

Employer____Work Phone_______________________________

Spouse's Name____DOB____________Cell Phone______________________________

In Case of Emergency, contact:

Name____Relationship____

Cell Phone ____Work Phone____

ADULT HEALTH HISTORY

Name of physician____Date of last physical exam___________________________

☐ Yes ☐ No Are you currently taking any medications? Name____

Doses and reason ____

☐ Yes ☐ No Are you allergic to anything?____

☐ Yes ☐ No Have you ever been hospitalized? Please give reason and dates______________________________________

☐ Yes ☐ No Have you had any operations? ____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

☐ AIDS/HIV	☐ Circulatory Problems	☐ Hepatitis Type ____	☐ Rheumatic Fever
☐ Anemia	☐ Congenital Heart Lesions	☐ Herpes	☐ Shortness of Breath
☐ Arthritis	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valves	☐ Persistent Cough	☐ Frequent infections	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaundice	☐ Special Diet
☐ Asthma	☐ Emphysema	☐ Kidney Disease	☐ Stroke
☐ Back Problems	☐ Epilepsy	☐ Liver Disease	☐ Swollen feet/ankles
☐ Bleeding Abnormally	☐ Fainting/Dizziness	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Nervous Problems	☐ Tuberculosis
☐ Cancer	☐ Headaches	☐ Psychiatric Care	☐ Tumor head/neck
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Weight Loss	☐ Contact Lenses	☐ Pregnant	☐ Nursing

CONSENT FOR DENTAL TREATMENT

You have a right to accept or reject dental treatment. Prior to consenting you should consider the benefits and risks of the procedure, alternative treatments, and the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Small risks may include swallowing or inhaling of saliva or dental materials, discomfort, bleeding, post numbing bite trauma, bruising, swelling, numbness or allergic reaction. The dentists do everything possible to minimize or completely prevent these risks and side effects. I understand that drugs and medications including antibiotics, analgesics, and other medicines can cause allergic reactions resulting in redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction). By signing this consent you are allowing the dentists at Children's Dentistry of Northborough to diagnose and treat you. I consent to receive cleanings, dentist examinations, fluoride treatments, photographs, and x-rays. Should I agree to a treatment plan, I consent to allow the providers at this office to do sealants, fillings, and other common dental procedures within the standards of care for the duration of my time as a patient. If I wish not to consent to any of the above I agree to inform the dentist the day of my appointment.

Signature ____ **Date** ____________________