DR. DALESANDRO & ASSOCIATES
FAMILY OWNED SINCE 1978

HEALTH HISTORY

1. Do you have any pain from any area of your mouth? YES___ NO___ If YES, where?___________________

2. Are you in good health? YES___ NO___ 3. When was your last physical examination?___________________

4. Are you now under the care of a physician? YES___ NO___ Physician's Name & Phone: ___________________

5. Have you been hospitalized or had a serious illness within the past 5 years? YES___ NO___ If YES, explain:___________________

6. Are you now taking any medication, drugs or pills? YES___ NO___

If YES, please list those medications/drugs & reason:___________________

7. Y N Conditions	Y N Conditions	Y N Conditions	Y N Conditions	Y N Allergies
☐ ☐ Abnormal Bleeding	☐ ☐ Cosmetic Surgery	☐ ☐ Hemophilia	☐ ☐ Rheumatic Fever	☐ ☐ Aspirin
☐ ☐ Alcohol Abuse	☐ ☐ Diabetes	☐ ☐ Hepatitis A	☐ ☐ Seizures	☐ ☐ Codeine
☐ ☐ Allergies	☐ ☐ Difficulty Breathing	☐ ☐ Hepatitis B	☐ ☐ Shingles	☐ ☐ Dental Anesthetics
☐ ☐ Anemia	☐ ☐ Drug Abuse	☐ ☐ High Blood Pressure	☐ ☐ Sickle Cell Disease	☐ ☐ Erythromycin
☐ ☐ Angina Pectoris	☐ ☐ Emphysema	☐ ☐ HIV+ AIDS	☐ ☐ Sinus Problems	☐ ☐ Jewelry
☐ ☐ Arthritis	☐ ☐ Epilepsy	☐ ☐ Kidney Problems	☐ ☐ Stroke	☐ ☐ Latex
☐ ☐ Artificial Bones	☐ ☐ Fainting Spells	☐ ☐ Liver Disease	☐ ☐ Thyroid Problems	☐ ☐ Metals
☐ ☐ Artificial Heart Valve	☐ ☐ Fever Blisters	☐ ☐ Low Blood Pressure	☐ ☐ Tuberculosis	☐ ☐ Penicillin
☐ ☐ Asthma	☐ ☐ Frequent Headaches	☐ ☐ Mitral Valve Prolapse	☐ ☐ Ulcers	☐ ☐ Tetracycline
☐ ☐ Blood Transfusion	☐ ☐ Glaucoma	☐ ☐ Pace maker	☐ ☐ Venereal Disease	Other
☐ ☐ Cancer-Chemotherapy	☐ ☐ Hay Fever	☐ ☐ Pneumocystitis	☐ ☐ Yellow Jaundice	___________
☐ ☐ Colitis	☐ ☐ Heart Attack	☐ ☐ Psychiatric Problems		___________
☐ ☐ Congenital Heart Defect	☐ ☐ Heart Surgery	☐ ☐ Radiation Therapy		

8. Do you get up often at night to urinate? YES___ NO___ 9. Are you thirsty much of the time? YES ___ NO ___

10. Has anyone in your family had diabetes? YES___ NO___ 11. Do you smoke? YES___ NO___ How much? _______

12. Do you consider yourself a nervous person? YES___ NO___ 13. Do you take bisphosphonates? YES___ NO___ How much?_______

14. Do you have any disease, condition or problem not listed above that you think we should know about? YES___ NO___

If YES, please explian:___________________

15. FOR WOMEN ONLY; Are you pregnant? YES___ NO___ If YES, what month?___________ Are you Nursing? YES___ NO___

CONSENT

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs or any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor with my verbal consent to perform any and all forms of treatment, medication and therapy after the Doctor explains the condition in connection with (patient) ___________________, and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies risk. I understand that responsibility for payment for dental services provided in this office for myself and/or my dependents is mine, **due and payable at the time services are rendered.** If I do not pay the full balance at the time of service and/or have not made financial arrangements for the balance, I understand that a 1.5% finance charge per month (18% annually) will be added to any balance over 90 days'. **Furthermore, I understand that a cancellation fee of $45 will be charged unless 2 working days' notice is given for appointment changes.**

Signature: ___________________ Date:___________ Relationship to Patient:___________