ALTITUDE DENTAL

FAMILY DENTISTRY | PROSTHODONTICS | DENTAL IMPLANTS | COSMETIC DENTISTRY

Information Update

Our team looks forward to bringing you into our family of patients. Please help us meet all your dental needs by completing this form. If you have any questions or need assistance, please ask us – we will be happy to help.

Please complete the following confidential information:

Dr./Mr./Mrs./Ms./Miss Name: _____ Date of Birth: _____

SS#: _____ Employer: _____ Preferred Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

How did you hear about us? _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Note: Please present your driver's license for us to photocopy and keep within your file. Thank you.

Driver's License State: _____ Number: _____

Consent for Treatment

1. I hereby authorize Dr. Rolfes or designated staff to take x-rays, study models, photographs, and any other diagnostic procedures needed for Dr. Rolfes to make a thorough diagnosis of _____'s dental needs.

(Name of Patient)

2. Upon such diagnosis, I authorize Dr. Rolfes to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication, as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for an explanation of any possible complications.

Patient: _____ Date: _____

Parent or Responsible Party Signature: _____

Medical History

1. Have you been under the care of a medical doctor during the past two year____YES NO
   If yes, please list: _____

   Primary Physician:_____ Phone:_____
   Address:_____City:_____State:_____Zip:_____
2. Have you taken any medication or drugs during the past two years_____ YES NO
   If yes, please list ALL: _____
3. Are you taking any mediations or drugs now?_____YES NO
   If yes, please list ALL:_____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? _____ YES NO
5. Do you need to be premedicated with antibiotics for dental procedures_____ YES NO
   If yes, please list prescribing physician: _____ Phone:_____
   Please list the medication prescribed: _____
6. Have you been a patient in the hospital during the past five years?_____ YES NO
   If yes, please list?_____
7. Women: Are you pregnant? NO Yes
   If yes, how many months? _____Nursing? _____Taking birth control pills? NO YES
8. Do you have, or have had any disease or condition, or problem not listed below? Yes NO
   If yes, please list:
9. Indicate which of the following you have had or have currently. Circle "YES" or "NO" to each item.

A.I.DS	YES NO	EMPHYSEMA	YES NO	MITRAL VALVE PROLASPE	YES NO
ALLERGIES/HIVES	YES NO	EPILEPSY/SEIZURES	YES NO	NERVOUS/ANXIOUS	YES NO
ARTHRITIS/RHEUMATISM	YES NO	FAINTING OR DIZZINESS	YES NO	NEUROLOGICAL DISORDERS	YES NO
ARTIFICAL HEART VALVE	YES NO	GLAUCOMA	YES NO	PSYCHIATRIC/PSYCHOLOGICAL CARE	YES NO
ARTIFICIAL JOINTS	YES NO	H.I.V POSITIVE	YES NO	RADIATION THERAPY	YES NO
ASTHMA	YES NO	HAY FEVER	YES NO	RHEUMATIC FEVER	YES NO
BLOOD TRANSFUSION	YES NO	HEART SURGERY/ATTACK	YES NO	SICKLE CELL DISEASE	YES NO
BRUISE EASILY	YES NO	-IF SO, WHEN?		SINUS TROUBLE	YES NO
CHEMOTHERAPY	YES NO	HEART MURMUR	YES NO	STROKE	YES NO
CHEST PAIN	YES NO	HEART PACEMAKER	YES NO	SWOLLEN ANKLES	YES NO
COLD SORES/BLISTERS	YES NO	HEMOPHILIA	YES NO	THYROID PROBLEMS	YES NO
CONGENITAL HEART DISEASE	YES NO	HEPATITIS An INFECTIOUS B SERUM	YES NO	TUBERCULOSIS	YES NO
CONTACT LENSES	YES NO	HIGH BLOOD PRESSURE	YES NO	TUMERS	YES NO
CORTISONE MEDICINE	YES NO	KIDNEY TROUBLE	YES NO	ULCERS	YES NO
DIABETES	YES NO	LATEX SENSITIVITY	YES NO	VENEREAL DISEASE	YES NO
YELLOW JAUNDICE	YES NO	LIVER DISEASE	YES NO		