Date: _____

Health History and Consent

Patient Information

Required information is marked in bold type. You must provide this information in order for us to provide treatment. Other information is optional, but may be required for some of our services.

Last Name: _____ **First Name**: _____

Date of Birth: _____/ _____ / _____(MM / DD / YYYY)

Address: _____

City: _____ **Province**: _____ **Postal Code:**_____

Cell Phone: _____ **Home Phone**: _____
Work Phone: _____ **Ext:** _____ _____
Email Address: _____

How did you hear about our office? _____

Emergency Contact or Parent/Guardian:

Last Name: _____ **First Name**: _____

Address: _____

City: _____ **Province**: _____ **Postal Code:**_____

Cell Phone: _____ **Home Phone**: _____
Work Phone: _____ **Ext:** _____ _____
Email Address: _____

Relationship to patient: _____

Insurance Information

Primary Insurance

Last Name: _____ **First Name:** _____

Date of Birth: ___ / ___ / ___ (M / D / Y)

Employer / Company: _____
Insurance Company: _____
Policy / Group: _____
ID / Certificate: _____

Secondary Insurance

Last Name: _____ **First Name:** _____

Date of Birth: ___ / ___ / ___ (M / D / Y)

Employer / Company: _____
Insurance Company: _____
Policy / Group: _____
ID / Certificate: _____

If this is an accident claim, we require the following information:

Insurance Company: _____
Mailing Address:_____
Phone Number: _____ Fax Number: _____
Adjuster's Name:_____
Claim / File Number:_____Date of Loss: _____ / _____ / _____ (MM / DD / YYYY)

Medical History:

1. Do you have any current health problems? Yes Not Sure No
2. Are you currently under the care of a physician? Yes Not Sure No
   Name of physician:
3. Are you presently taking any pills, drugs, or medication? Yes Not Sure No
   Please Specify:
4. Have you taken any prolonged medication in the past: Yes Not Sure No
   Please Specify:
5. Do you have any allergies? Yes Not Sure No
   Please Specify:
6. Have you ever been hospitalized: Yes Not Sure No
   Please Specify:
7. Have you taken cortisone or steroids?
8. Have you gained or lost excessive weight lately? Yes Not Sure No
9. Have you ever had radiation or chemotherapy? Yes Not Sure No
10. Are you pregnant? Yes Not Sure No

Due Date:_____

11. Have you ever had any of the following?

Arthritis	У	N	Heart Attack or Stroke	У	N
Aergies Artificial Joints	У	N	Heart Murmur	У	N
Anemia Arteriosclerosis	У	N	Heart surgery/pacemaker	У	N
Asthma AIDS/HIV Birth	У	N	Hearing Disorders	У	N
Defects	У	N	Hepatitis	У	N
Blood Disorders	У	N	High/Low Blood Sugar	У	N
Bruises Easily	У	N	History of Substance Abuse	У	N
Cancer	У	N	Hypertension(High BP)	У	N
Cosmetic Surgery	У	N	Hypotension(Low BP)	У	N
Congenital Heart Defects	У	N	Intestinal Disorders	У	N
Diabetes	У	N	Kidney Problems	У	N
Dizziness	У	N	Liver Problems	У	N
Emotional Problems	У	N	Mitral Valve Prolapse	У	N
Epilepsy	У	N	Nervous Disorder	У	N
Emphysema	У	N	Numbness of Arms/Hands	У	N
Fainting	У	N	Pneumonia	У	N
Fever or Sun Blisters	У	N	Psychiatric Treatment	У	N
Glaucoma	У	N	Ulcers	У	N
Hay Fever	У	N	Rheumatic Fever	У	N
Herpes	У	N	Swollen,Stiff,Painful,Joints	У	N
Head or Face Injury	У	N	Scarlet Fever	У	N
			Shortness of Breath	У	N
			Sinus Problems	У	N
			Thyroid Problems	У	N
			Venereal Disease	У	N

DENTAL HISTORY

1. When was your last dental visit: _____
2. Are you having any discomfort at this time: YES NOT SURE NO
   Please Specify: _____
3. Have you ever been given local anesthetic (freezing): YES NOT SURE NO
4. Are you aware of any lumps or swelling in your mouth? YES NOT SURE NO
5. Are you satisfied with the appearance of your teeth? YES NOT SURE NO
   Please Specify: _____
6. Do you have partial or full dentures? YES NOT SURE NO
   Are you satisfied with your dentures? YES NOT SURE NO
   Please Specify: _____
7. Do you experience a popping or clicking in your jaws? YES NOT SURE NO
8. Do you experience any of the following?

Tender Gums	Yes	Not Sure	No	Bleeding Gums	Yes	Not Sure	No
Loose Teeth	Yes	Not sure	No	Sensitive Teeth	Yes	Not Sure	No
Ear Pain	Yes	Not Sure	No	Headache	Yes	Not Sure	No
Bad Breath	Yes	Not Sure	No	Neck Pain	Yes	Not Sure	No
Gagging	Yes	Not Sure	No				

CONSENT FOR TREATMENT (please initial)

_____ I am aware that Dr. Brock Rondeau Dentistry P.C. is keeping the personal information outlined in the "Your Personal Information, the PIPED ACT, and your Dentist" handout for the reasons disclosed. I have been informed that my files may be audited and that the members of the staff of Dr. Brock Rondeau Dentistry P.C. may access this information. I give my consent for this information to be collected and disclosed as outlined to me.

_____ You may consult another medical professional about my case.

_____ You may respond to other medical professional's inquiries about my case.

_____ You may use my information for teaching or seminars through Rondeau Seminars.

CONSENT FOR TREATMENT (please initial)

_____ I consent to the performing of the dental procedures agreed to be necessary

I certify that the information provided above is accurate to the best of my knowledge. I give my Consent for the actions and disclosures outlined above.

Name:_____ Signature:_____
Date:_____

If Parent or Guardian is signing:

Name:_____ Signature:_____
Relationship to Patient:_____