Dental / Medical History (Confidential)

New Patient Form

Patient Name:	Phone. Home:
Address:	Phone. Work:
Date of birth:	Cell:
SSN:	E-Mail-Address:

Health Information

Yes	No	
☐	☐	Are you in good health
☐	☐	Do you presently have pain?
☐	☐	Are you under physician's care now?

Have you ever had:

☐	☐	Abnormal heart Condition?
☐	☐	Artificial valve?
☐	☐	Rheumatic fever?
☐	☐	Diabetes?
☐	☐	Abnormal Bleeding?
☐	☐	Artificial joint?
☐	☐	Unusual reaction to any drugs or Local Anesthetic?
☐	☐	Oral Contraceptives? (Antibiotics Render oral contraceptives effectives)
☐	☐	Tuberculosis?
☐	☐	Radiation Treatment?
☐	☐	Abnormal Blood Pressure?
☐	☐	Hepatitis?
☐	☐	Blood transfusion? (Give date)
☐	☐	Veneral disease?
☐	☐	AIDS or HIV-positive?
☐	☐	Allergies? (Specify)
☐	☐	Jaw joint pain, clicking, etc.?
☐	☐	Females, are you pregnant?
☐	☐	Is there any other information about your health we should know?

I certify that the answers to the health are accurate and correct to the best of my knowledge. Since a change of medical conditions or medications can affect dental treatment, I understand the importance of and agree to notify the dentists of any changes are any subsequent appointment.

Signature	Date

Informed Consent

I authorize Dr. Doryumu and or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which my include, but are not limited bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical treatments.

I understand that as part of dental treatment, including preventive procedures such as cleaning, bleaching and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful, both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Payment of dental services should be made immediately following treatment bills leaving the office. I authorize the dentist to release information including and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I certify that I have answered all questions on from accurately and to the best of my knowledge. I hereby do abide by the conditions outlined here in.

Signature	Date