Friends of Family
Health Center

Patient Name : ______________________________ DOB: __________________

INSTRUCTIONS

Answer all questions and fill in blank using a check mark X. Answers to the following questions are for our records only and will be confidential.

	Yes/Si	No
Has there been any major change in your health? ………………………..	_____	_____
Are you now under the care of a physician?...	_____	_____
If so, what is the condition being treated? _________________		
Do you have or had any of the following diseases or problems?	_____	_____
Damaged heart valves or artificial heart valves?	_____	_____
Congenital heart lesions or murmurs …………………………………….....	_____	_____
Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, low blood pressure, stroke)		
HIV/AIDS……………………………………………………………..…………	_____	_____
Sinus trouble…………………………………………………...……………	_____	_____
Asthma or frequent bronchitis…………………………………….………..	_____	_____
Hives or skin rash……………………………………………………………..	_____	_____
Seizures…………………………………………………………..……….	_____	_____
Diabetes………………………………………………………………………	_____	_____
Hepatitis, jaundice or liver disease…………………………………………..	_____	_____
Arthritis ………………………………………………………………………	_____	_____
Inflammatory rheumatism (painful, swollen joints) ………………………..	_____	_____
Stomach ulcers ………………………………………………………………..	_____	_____
Kidney trouble…………………………………………………………………	_____	_____
Tuberculosis…………………………………………………………………...	_____	_____
A persistent cough or coughs up blood……………………………………....	_____	_____
Do you have any disease, condition or problem not listed? ……………...	_____	_____
If so, what? ____		
Autism ………………………………………………………………………..	_____	_____
Cerebral Palsy………………………………………………………………	_____	_____
Bleeding Disorder…………………………………………………………	_____	_____
Do you have an artificial hip or joint, implants, bone plates or screws? ...	_____	_____
If so, what? ____		
Have you ever had a serious illness, or operation or hospitalization …....	_____	_____
If so, What? ____		
Allergies to food or environment…………………….………………………	_____	_____
Are you pregnant ………………………………………………………………	_____	_____
Do you have any allergies?..	_____	_____
If so, What? ____		
Are you taking any prescription or over the counter medication ………...	_____	_____
If so, What? ____		
Name of Physician: __________________________________		
Phone Number: _____________________________________		

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware.

________________________________ __________
Patient/Parent/Legal Guardian Signature Date

Relationship to patient/ ☐Father ☐Mother ☐Other:

____
Doctor Signature Date

Office Use Only

____
Date

____________________ ____________________
Patient's Signature Relationship to patient

____
Provider's Signature

____
Date

____________________ ____________________
Patient's Signature Relationship to patient

____
Provider's Signature

____
Date

____________________ ____________________
Patient's Signature Relationship to patient

____
Provider's Signature

Patient Name: _______________________________________DOB:_________________Chart #: _________________

Late or Cancelled Appointment

As a patient or the parent or guardian of a patient if Friends of Family Health Center I understand that if I find it necessary to cancel a scheduled appointment, I will notify the Center at least 24 hours in advance by phone, mail or in person. Payment is required at the time of each appointment. If I am 15 minutes late, my appointment may have to be rescheduled to keep the dental schedule on time. If I come to the Dental Clinic without a scheduled appointment I may or May not be seen depending on the Dental Clinic schedule.

Consent for Treatment

I give my consent to the use of all services deemed necessary to complete the required treatment including, but not limited to the administration if anesthesia, radiology, intra oral pictures and any needed medication. I understand that should my child/myself become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the child's or yourself hands and arms to stabilize the head and/or control leg movement. I also understand that no warrantee or guarantee can be made as to the results of treatment. I hereby agree to release this Clinic and its employees from further responsibility with regards to permission for treatment.

Treatment consent must be signed by the legal guardian. If legal guardian cannot bring the child to their appointment and legal guardian must provider written authorize for the individual bring the child to the appointment.

Consent for Services

The dental procedure to be performed has been explained to me, and I understand what is to be done. This is my consent to the treatment plan indicated and to any other treatment deemed necessary or advisable depending on the judgement of the attending doctor.

I have been informed and understand that occasionally there are complications of the surgery, drugs and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness, and occasionally inflammation of the skin (thrombophlebitis) may occur from injection. Less common complications include the possibility of injury to the adjacent teeth, restorations, in other teeth, or to other tissues, referred pain to the ear, neck, head, nausea, vomiting, allergic reaction, bone fractures, and delayed healing. Sinus complication, which may include a nasal antral fistula or opening into the sinus from the mouth, may occur with removal of upper teeth.

Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which could be increased by the use of alcohol or other drugs. Thus I have been advised not to operate any vehicle or hazardous device for at least 24 hours until I have fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care.

I acknowledge the receipt of and understand the post-operative instructions. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I understand that I can ask for a full recital of any and all possible risk attendant to my care by just asking.

Parent/Patient Signature: ____ Date: _____________