

Y N High blood pressure
 Y N Irregular heartbeat
 Y N Heart attack year _____
 Y N Coronary bypass/stents year _____
 Y N Artificial heart valve year _____
 Y N Pacemaker or defibrillator year _____
 Y N Stroke year _____
 Y N Heart murmur
 Y N Chest pain
 Y N Shortness of breath
 Y N Asthma, emphysema, COPD
 Y N Tuberculosis
 Y N Hepatitis/ liver disease
 Y N Gastric reflux disease
 Y N Ulcers/ bowel disease
 Y N Kidney disease
 Y N Arthritis or skeletal disorders
 Y N Total joint replacement(s) year _____
 Y N Bleeding/ clotting disorders

Y N Anemia
 Y N Diabetes
 Y N Thyroid/endocrine disease
 Y N Immune system disease, +HIV, AIDS
 Y N Seizures or nerve disorders
 Y N Fainting or dizziness
 Y N Chronic pain/ fibromyalgia
 Y N Clinical depression
 Y N Other psychiatric disease
 Y N Radiation treatment, Site: _____
 Y N Cancer chemotherapy
 Y N Prior/current use of Zometa or Aredia
 Y N Prior/current use of osteoporosis medications
 Y N Alcohol: _____ drinks/week
 Y N Tobacco or other nicotine _____
 Y N Prior/current drug abuse
 Describe _____
 Y N Currently pregnant
 Y N Currently breast feeding

Are you under current care with a pain management doctor? Yes No

Please describe any other serious illnesses or conditions:

Please describe any prior surgeries or complications to surgery or anesthesia:

Current or recent medications:

Condition being treated: (attach list, if necessary):

Please list all significant medical allergies:

Your Height: _____ Weight: _____ Age: _____ Your physician's name: _____

Please initial the following paragraphs:

_____ I consent to a physical and radiographic exam and to consultation with my dentists or physicians.

_____ I have received and had opportunity to read the current HIPAA "Notice of Privacy Practices" and consent to the disclosure of my private information in accordance with the policy of this office.

_____ **I am solely financially responsible for and agree to pay all treatment costs** - regardless of any insurance coverage. I consent billing insurance for procedures and to assignment of insurance benefits to pay this office directly. There are charges for failed appointments. If signing for a minor or ward, I certify my signature alone is sufficient to consent to exam and treatment and that I am solely responsible for all treatment costs incurred.

Signature of Patient or Parent/Guardian or responsible party:

Date

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