Check medications that you currently take:

__Antibiotics or Sulfa Drugs
__Anticoagulants
__High Blood Pressure Medication
__Steroid Medication
__Antihistamines
__Aspirin
__Insulin / Oral hyperglycemic Medications
__Digoxin or other Heart Regulating Drugs
__Nitroglycerin
__Chemotherapy
__Sleeping Pills
__Psychiatric Drugs
__Vitamins/Herbal Supplements (List)_____
__Other (List)_____

Check any allergies that you have:

__Local anesthetic drugs
__Penicillin or other antibiotics
__Sulfa Drugs
__Barbiturates, Sleeping pills
__Aspirin
__Iodine
__Codeine or other Narcotic medications
__Metals
__Other (List)_____

To the best of my knowledge, all of the preceding questions have been answered to the best of my knowledge and are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Dental Office at the next appointment and realize that I will need to fill out a health history update on a yearly basis.

I understand that if, during the course of my treatment in this office, the Dentist or employee may have an accidental exposure to my blood. a specimen of my blood may be requested and tested for the prescence of blood borne diseases. The results of such tests or the exposure will remain confidential and will not become a part of my permanent record.

I will consent to the use of photographs, X-ray films, impressions, and other laboratory tests where they are indicated for the purpose of diagnosing and treatment planning.

I understand that all original dental records, X-ray films, and diagnostic aids are the property of Fischer Family Dentistry and cannot be taken, or originals sent from the dental office. Copies will be provided upon written request and sent to another dental facility but will be assessed a fee for X-ray duplicating, copying the chart, and postage which must be paid prior to any chart information being sent.

I understand that if I fail to show for my scheduled dental appointments or fail to give 24 hour cancellation notice that I may be charged a "Missed Appointment" Fee and/or not allowed to schedule any further appointments at Fischer Family Dentistry.

_____ _____

Date *Signature (Patient 18 yrs and older), Parent/Legal Guardian*