ELIZABETH KILPATRICK-FOX, D.M.D.

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name _____ Phone No. _____

   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO

   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES.	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Developmentally Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes, what month? _____ ❑ No Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and the the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Futhermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account.
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

EXAMINATION - TREATMENT - PLAN RECORD

DENTAL HISTORY:

Purpose of initial visit _____

_____

Are you aware of a problem _____

_____

How long since your last dental visit _____

What was done at that time _____

_____

Previous Dentist _____

_____

Have you made regular visits _____

Were dental x-rays recently taken _____

Have you lost any teeth _____ Why _____

Were there any complications after tooth removal _____

_____

Have they been replaced _____ When _____

How _____

_____

Do you clench or grind your teeth _____

Does your jaw click or pop _____

Have you experienced any pain or soreness in the muscles of your face or around the ear _____

Does food get caught between your teeth _____

Are any teeth sensitive to hot _____ cold _____

sweets _____ pressure _____

How often do you brush your teeth _____ when _____

Do your gums bleed or hurt when brushing _____

Do you use dental floss _____

How often _____

Has anybody told you your breath is offensive _____

How do you feel about your teeth in general _____

_____

Are you happy with the appearance of your teeth _____

Have you had any unpleasant dental experiences or anything about dentistry that you strongly dislike _____

_____

Do you have any questions or concerns _____

_____

RADIOGRAPHS REQUIRED (Enter on radiographic log after taking).

BW_____ PAN_____ FMX_____ PA_____ Other_____

CLINICAL EXAMINATION

5.1 ORAL, SOFT TISSUE AND TMJ EXAMINATION

PERIODONTAL EXAMINATION