Rasmussen
Prosthodontics
Implant, Fixed, Removable and Maxillofacial Prosthodontics

Patient Health History

Name:____ Date of Birth:_________________________

Are you presently under the care of another dentist? YES ☐ NO ☐ Dentist's Name:________________

Medical Doctor's Name:__________________________________ Phone #:____________________________

Medical Doctor's Address:____

Describe your general health:____

Do you have any allergies to any metals? YES ☐ NO ☐ If so, what?____________________________

Do you have any allergies to any medications? YES ☐ NO ☐ If so, what?____________________________

If female, are you pregnant? YES ☐ NO ☐ If yes, How many months?_______________

Have you had or do you have any serious illness and/or surgery in the last 2 years? YES ☐ NO ☐

What and when?____

Are you presently under a doctor's care? YES ☐ NO ☐

For what?____

Are you taking any drugs and/or medications? YES ☐ NO ☐

List drugs/medications:____

Have you had, taken, or do you now have or are you taking any of the following?

Radiation Therapy	YES ☐ NO ☐	Implants	YES ☐ NO ☐
Anemia	YES ☐ NO ☐	Hip, Shoulder, Dental, Knee, Other?	____________
Diabetes	YES ☐ NO ☐	Are you HIV Positive?	YES ☐ NO ☐
Rheumatic Fever	YES ☐ NO ☐	Problems w/ local anesthesia?	YES ☐ NO ☐
Heart Murmur	YES ☐ NO ☐	Fen Phen	YES ☐ NO ☐
High or Low Blood Pressure	YES ☐ NO ☐	Fosomax, Actinil, Bonivia	YES ☐ NO ☐
Heart Disease	YES ☐ NO ☐	Have you had a blood transfusion	
Hepatitis	YES ☐ NO ☐	Within the Last 12 months?	YES ☐ NO ☐
Cancer	YES ☐ NO ☐	Other_________________________	

Terms and Conditions:

Payment is due at time services are rendered unless other arrangements have been made. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This dental office will help prepare the patient's insurance forms to assist in making collection from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumptions that our charge will be paid by an insurance company. Note 1.5% per month (18% APR) interest will be charged on overdue accounts, past 60 days. In case of default, I agree to pay reasonable costs for collection including arbitration/mediation costs, attorney fees, court costs, etc.

Broken Appointments:

There is a $25.00 charge for all appointments that are broken without a 24-hour cancelation notice to the office. I agree to pay this fee if I fail to properly notify the office in the event of cancellation.

Consent for Treatment:

I hereby grant authority to the dentist(s) in charge of the patient whose name appears on this Health History form to administer any treatment, anesthetics, analgesics, sedatives, and nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Notice of Privacy Practice:

Your privacy is important to us. We are committed to complete confidentiality of our patients and customers. We pledge to not share patient information of any sort with any entity unless directed to do so in writing by our patients. Any requests for information or complaints about information release can be directed to the doctor who will provide the appropriate documentation.

Signed:____ Date:______________________

Doctor's Notes:

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