



WAYNE G. THORPE, D.D.S., P.C.

HISTORY

Patient's Name, Soc. Security No., Today's Date, Patient's Birth Date, Age, Patient's Weight, Height, Mail address, City and State, Zip Code, Home Phone, Name of person responsible for account, DOB, SS#, Employer, Business Phone, Spouse, Spouse's Employer, Spouse's Business Phone, Dental Insurance Co., Policy #, Medical Insurance Co., Policy #, Referred by, Phone, Name of Nearest Relative, Phone

MEDICAL HISTORY

Physician's Name, Phone, Date of last visit, Have you had any serious illnesses or operations?, If yes, describe, Are you currently under physician care?, Have you ever had a blood transfusion?, Have you ever taken Fen-Phen/Redux?, Women: Are you pregnant?, Nursing?, Taking birth control pills?, Men: Are you taking, or have you taken Viagra?, Are you taking Aredia or Zometa?

Check (✓) yes or no whether you have had any of the following:

- Checklist of medical conditions: AIDS/HIV Positive, Anaphylaxis, Anemia, Angina, Anorexia (eating disorder), Anticoagulants (blood thinners), Arthritis, Rheumatism, Artificial heart valves, Artificial joints, Asthma, Atopic (allergy prone), Back problems, Blood disease, Cancer, Chemical dependency, Chemotherapy, Circulatory problems, Cortisone treatments, Cough, persistent, Cough up blood, Diabetes, Epilepsy, Fainting, Glaucoma, Headaches, Heart murmur, Heart problems, Hemophilia/ Abnormal bleeding, Herpes, Hepatitis/Jaundice, High blood pressure, Jaw pain, Kidney disease or malfunction, Liver disease, Lung Trouble (shortness of breath), Material allergies (latex, wool, metal, chemicals), Mitral valve prolapse, Nervous problems, Pacemaker/Heart surgery, Psychiatric care, Rapid weight gain or loss, Radiation treatment, Respiratory disease, Rheumatic/Scarlet fever, Shingles, Skin rash, Stroke, Surgical implant, Swelling of feet or ankles, Thyroid disease or malfunction, Tobacco habit, Tonsillitis, Tuberculosis, Ulcer/Colitis, Venereal disease

Is patient currently taking any medications? If yes, list all: Does patient have drug allergies? If yes, list all:

Have you had an unfavorable reaction to local or general anesthesia? YES NO, How much do you drink and/or smoke?, Why do you seek treatment today? (Such as pain, swelling, bleeding, etc.)

CONSENT TO OPERATION OR OTHER MEDICAL-DENTAL PROCEDURE

I (full name of patient) consent to the following procedure

under the direction of DR. WAYNE G. THORPE.

INFORMED CONSENT

The necessary surgery has been fully explained to me. I hereby give DR. WAYNE G. THORPE and assistants of choice my consent to the performing of the surgery and whatever procedures may be deemed necessary or advisable in addition to the planned operation. I understand the hazards in connection with these procedures such as: serious bodily harm and even death; swelling, bruising, infection, tingling or numbness of the lips, tongue, gums, and/or face; loss or damage to other teeth or restorations/ phlebitis of the arm; wrist or hand; root or tooth into the sinus; oral antral fistula, maxillary sinusitis; changes to T.M.J.; possible mandibular fracture; and post operative hemorrhage, bruises and discomfort. I understand that I am not to operate any vehicle or hazardous device, or drink alcoholic beverages, for at least 24 hours or until fully recovered from the anesthetic and/or medications. I agree to the use of a local or general anesthetic, sedation and analgesia depending on the judgment of the dentists involved in my case. I have been informed of the possible complications of the surgery, anesthesia, and other drugs and medication. The fee for these services has been explained to me and is satisfactory. I have been advised of other treatment modalities and choose to have oral surgery.

Date, Signature of Patient, Parent or Guardian, Signature of Witness