Brian L. Homer DMD, PC
7369 Creek Road
Sandy, Utah 84093
(801) 566-5577

Medical History Form

1 General Information

Does the Patient require antibiotic pre-medication before treatment? ☐ Yes ☐ No Prescription Name: ____________

Is the Patient pregnant? ☐ Yes ☐ No Anticipated due date? ____________

Does the Patient use tobacco? ☐ Yes ☐ No

What type of tobacco? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Snuff

Current Medications (including birth control): ____________

Has the patient been under a physician's care within the past year? ☐ Yes ☐ No

If Yes, specify the condition being treated: ____________

Do you have or have you ever had bleeding or sensitive gums? ☐ Yes ☐ No

Has the patient ever taken Fosomax, Actonel, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? ☐ Yes ☐ No

2 Medical Conditions

Does the Patient have, or has the Patient had any of the following?

☐ Heart Disease	☐ Diabetes	☐ Psychiatric Treatment	☐ Liver Disease
☐ High Blood Pressure	☐ Stroke	☐ Arthritis	☐ Kidney Disease
☐ Blood Disorder	☐ Epilepsy	☐ Radiation Treatment	☐ Hepatitis
☐ Anemia	☐ Fainting	☐ Tumor History	☐ Jaundice
☐ Rheumatic Fever	☐ Asthma	☐ Sinus Trouble	☐ Tuberculosis
☐ Heart Murmur	☐ HIV History	☐ Ulcers	☐ Joint Replacement/Prosthetic
☐ Thyroid Condition	☐ Glaucoma	☐ Venereal Disease	☐ History of Drug/Alcohol Abuse

3 Patient Allergies

Does the Patient suffer from allergies to any of the following ?

☐ Penicillin	☐ Other Antibiotics	☐ Aspirin	☐ Codeine	☐ Local Anesthetic
☐ Metals	☐ Latex	☐ Epinephrine	☐ Other ____________	

I certify that the answers to the health questions contained in this form are accurate and correct to the best of my knowledge. Since a change of medical condition of medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

PATIENT'S NAME: ____________

SIGNATURE: ____________ DATE: ____________

(Patient, legal guardian or authorized agent of patient)

Consent to Proceed

I authorize Dr. Brian L. Homer and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

PATIENT'S NAME: ______________________________

SIGNATURE: ____________________________________ DATE: ____________________
(Patient, legal guardian or authorized agent of patient)

WITNESS: ______________________________________ DATE: ____________________