ROBIN WISE DDS

UNDENIABLE SERVICE.
UNFORGETTABLE SMILES.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)

____’s dental needs.

2. “I authorize the use of radiographs, photographs, or videotapes of my case for use in presentations or publications of the doctor.”

3. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

4. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

Patient’s Signature ___________________________________ Date ___________

Parent/Responsible Party’s Signature ______________________________________

Relationship to Patient ____

ROBIN WISE, DDS, FAGD

428 REMINGTON AVENUE • THOMASVILLE, GA 31792

www.southgeorgiasmiles.com

MEDICAL HISTORY

DATE ____________________

	YES	NO
Do you have any general health problems?	☐	☐
If so, please specify ______________________		
Are you currently under a physician's care?	☐	☐
Reason ______________________		
Name & Address of Physician: ______________________		
Are you currently taking any drugs or medication?	☐	☐
If so, what? ______________________		

To the best of your knowledge, are you or have you ever been afflicted with:

	YES	NO
Heart Ailment	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Hepatitis	☐	☐
Prolonged Bleeding	☐	☐
Healing Complication	☐	☐
Allergy to any Drugs	☐	☐
Would you like us to take your blood pressure?	☐	☐
Have you ever been told you should take an antibiotic before dental treatment for heart murmur, heart condition or artificial limbs or joints?	☐	☐

We would like to get to know you better!

NAME ______________________

ADDRESS ______________________

____

PHONE ______________________

OCCUPATION ______________________

EMPLOYER ______________________

ADDRESS ______________________

____

PHONE ______________________

DATE OF BIRTH ______________________

SOCIAL SECURITY # ______________________

MARITAL STATUS ______________________

SPOUSE'S NAME ______________________

EMPLOYER ______________________

ADDRESS ______________________

____

PHONE ______________________

WHOM MAY WE THANK FOR REFERRING YOU?

____

Person financially responsible for this account

____

Do you have a dental benefit plan? ______________________

If yes, carrier: ______________________

I hereby grant the right to the dentist and staff to release my dental /medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer as deemed necessary during my care.

____

Patient or Responsible Party Date

Medical History Review

Notes	Date
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________