

Your Name: _____

Name of Medical Physician: _____ Physicians' Phone Number: () _____

Have you been under the care of a medical doctor during the past two years? YES NO
If yes, what for: _____

Are you taking any medication? YES NO
If yes, please list: _____
_____ Pharmacy Phone Number: () _____

Are you allergic or have reacted adversely to any of the following medications? Please check.

- ___ Aspirin ___ Demerol ___ Nitrous Oxide ___ Penicillin ___ Darvon ___ Percodan
___ Codeine ___ Erythromycin ___ Tetracycline ___ Valium ___ Sulpha ___ Local Anesthetic

Are you allergic to any other medications: YES NO

If yes, please list: _____

Check any of the following which you have had or have at present:

- ___ Mitral Valve Prolapse ___ Herpes ___ Kidney Disease or Malfunction ___ Surgical Implants
___ Heart Murmur ___ High Blood Pressure ___ Cancer ___ Thyroid Disease
___ Anemia ___ Skin Rash ___ Stroke ___ Tobacco Habit
___ Hepatitis A, B, C ___ Sinus Trouble ___ Liver Disease ___ Tuberculosis (TB)
___ Arthritis/Rheumatism ___ Jaw Pain ___ AIDS/HIV ___ Respiratory Disease
___ Artificial Heart Valve ___ Epilepsy ___ Psychiatric Care ___ Chemical Dependency
___ Artificial Joints/Hip or Knee Replacement ___ Fainting ___ Chemotherapy ___ Material Allergies (latex, wood, etc.)
___ Asthma ___ Fever Blisters ___ Pacemaker/Heart Surgery ___ Hemophilia/Abnormal Bleeding
___ Angina Pectoris ___ Fen-Phen/Redux ___ Heart Problems ___ Rheumatic/Scarlet Fever
___ Back Problems ___ Food Allergies ___ Blood Transfusion ___ Other
___ Diabetes ___ Radiation Treatment ___ Venereal Disease ___ Other

For Women Only:

Are You Pregnant? YES NO

Are you taking birth control pills? YES NO

CANCELLATION POLICY

It is customary and a courtesy to provide us with notice of a change at least 24 hours in advance. This allows us the opportunity to schedule another patient in need. We do understand that extenuating circumstances happen. However, just as your time is valuable, so is ours. It is our policy to charge patients for a broken appointment unless it is an extreme emergency.

CONSENT

I have reviewed all the attached information and it is accurate to the best of my knowledge. I hereby give my authorization to Dr. Crosbie and Dr. Herndon to perform a thorough diagnosis in regard to my oral health and to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that xrays, study models and photographs will aid the doctor to determine the best possible treatment and therefore provide the highest quality of care.

I have read and understand the above:

Patient Signature

Date

Darren B. Crosbie, D.D.S. and J.Kent Herndon, D.D.S.
17110 Dallas Parkway, Suite 140, Dallas, TX 75248
Phone (972) 407-1333 Fax (972) 407-1681