J. Mark Bayless D.M.D., Inc. and Brandi Faia D.D.S.

Patient's Name: _____ **Nickname:** _____ **DOB:** _____

Father's Employer: _____ Mother's Employer: _____

Referred By: _____

Medical History (Please check Yes or No for each)

YES NO

☐ ☐ Patient is under the care of a physician at this time? If yes, why? Name of the physician?

_____

☐ ☐ Patient is presently taking medications? If yes, what and why?

_____

☐ ☐ Patient has an artificial heart valve(s), history of endocarditis, congenital heart conditions, or heart defect?

_____

Please check all of the following that your child has had a history of or condition related to:

YES	NO		YES	NO	
☐	☐	Allergy to antibiotics or other drugs: _____	☐	☐	Diabetes
☐	☐	ADD/ADHD	☐	☐	Ear/Throat Infection
☐	☐	Anemia	☐	☐	Epilepsy
☐	☐	Allergy to Eggs	☐	☐	GI Disease
☐	☐	Allergy to Latex	☐	☐	Hepatitis
☐	☐	Allergy to Soy	☐	☐	High/Low Blood Pressure
☐	☐	Allergy to other foods: _____	☐	☐	HIV? AIDS? ARC?
☐	☐	Allergy to Nuts	☐	☐	Kidney Disease
☐	☐	Anxiety Disorder	☐	☐	Liver Disease
☐	☐	Artificial Prosthesis, Organs, Joints, Implants	☐	☐	Mental Developmental Delay
☐	☐	Asperger's Syndrome	☐	☐	Physical Developmental Delay
☐	☐	Asthma	☐	☐	Pregnant
☐	☐	Autism Spectrum	☐	☐	Premedication Needed
☐	☐	Autoimmune Disease	☐	☐	Reactive Airway
☐	☐	Bleeding Disorder	☐	☐	Rheumatic Fever
☐	☐	Blood Disease	☐	☐	Seizure Disorder
☐	☐	Breathing Difficulty (enlarged adenoids/tonsils)	☐	☐	Sensory Issues
☐	☐	Cancer Therapy/Immunosuppression	☐	☐	Shunt
☐	☐	Celiac Disease	☐	☐	Sickle Cell Disease/Trait
☐	☐	Cleft Lip/Palate	☐	☐	Spina Bifida
☐	☐	Vascular Disease	☐	☐	Tuberculosis

Are there any health issues not listed above? _____

_____

I authorize J. Mark Bayless D.M.D., Inc. and Brandi Faia D.D.S. to examine my child in order to complete his/her own diagnosis prior to performing any dental treatment. This can include oral hygiene instruction, prophylaxis, and topical fluoride application. I understand the initial visit may require x-rays to complete a full diagnosis and treatment plan and I will be informed prior to taking any x-rays. I also understand on subsequent visits new x-rays may be required depending on my child's individual caries risk. I acknowledge that I am responsible for informing the doctor about any changes in the patient's health history prior to treatment. I understand the patient's health history information will be used as necessary for diagnosis or treatment by the doctors of J. Mark Bayless D.M.D., Inc and Brandi Faia, D.D.S. In this practice, radiographs, anesthetics, antibiotics, analgesics, sedatives, nitrous oxide-oxygen sedation, and dental restorative materials may be used. Any such treatment will be discussed with me in advance via a detailed treatment plan. **I acknowledge that I am financially responsible for all charges**. If requesting a payment plan, I authorize you to request a credit history report.

Signature: _____ _____ **Date:** _____

Responsible Party Relationship to Patient

For existing patients: Please initial and date after you have reviewed and updated all information. Please alert our staff if you have changed or added information.

INITIAL:_____ DATE:_____ INITIAL:_____ DATE:_____ INITIAL:_____ DATE: _____ INITIAL:_____