Name _____

Whom may we notify in case of emergency? (name, phone #, and relationship to you) _____

Name of Physician _____ **Phone #** _____

Clinic or Facility name _____

Yes ❑ No ❑ Any change in your health in the last year? _____

Yes ❑ No ❑ Are you currently under the care of a physician? If yes, describe your treatment: _____

_____

Yes ❑ No ❑ Have you had any medical treatment or physician visit of any kind in the last year?

If yes, describe: _____

_____

Yes ❑ No ❑ Have you ever had any surgical operation of any kind? If yes, describe: _____

Do you have, have you had, or been treated for any of the following:

Yes ❑ No ❑ *Rheumatic Fever*	Yes ❑ No ❑ *Hepatitis*	Yes ❑ No ❑ *Allergy* _____
Yes ❑ No ❑ *Heart Problems*	Yes ❑ No ❑ *Stomach Ulcers*	Yes ❑ No ❑ *Radiation or Chemical Therapy*
Yes ❑ No ❑ *High Blood Pressure*	Yes ❑ No ❑ *Kidney Disorder*	Yes ❑ No ❑ *Ear Infections*
Yes ❑ No ❑ *Low Blood Pressure*	Yes ❑ No ❑ *Tuberculosis*	Yes ❑ No ❑ *Chronic Sinus*
Yes ❑ No ❑ *Anemia*	Yes ❑ No ❑ *Venereal Disease; Herpes II*	Yes ❑ No ❑ *Asthma*
Yes ❑ No ❑ *Epilepsy; Seizures*	Yes ❑ No ❑ *Sexually Transmitted Disease, i.e. Aids*	Yes ❑ No ❑ *Hemophilia or Blood Disorder*
Yes ❑ No ❑ *Fainting Spells*	Yes ❑ No ❑ *Pacemaker*	_____ *Date(s) of any A.I.D.S. testing*
Yes ❑ No ❑ *Diabetes*	Yes ❑ No ❑ *Hip or Joint Replacement*	_____ *Date(s) of any Hepatitis testing*

Yes ❑ No ❑ Are you pregnant? Anticipated delivery date: _____

Yes ❑ No ❑ Do you use any tobacco (non-tobacco) products? If yes, what? _____

In what quantities? _____

Yes ❑ No ❑ Have you ever had an allergic reaction or been told not to take medication?

If yes, describe: _____

List all current prescription drugs (ex.: birth control, hormone, diet) and non-prescription drugs (ex.: aspirin, cough syrup, nasal spray, recreational drug use, high sugar intake, high caffeine intake) you are taking.

Name:	**Use:**
_____	_____
_____	_____
_____	_____
_____	_____

Notes: _____

_____

_____

I certify the above to be true and correct to the best of my knowledge.

Signature _____ **Today's date** _____

(patient or guardian of minor)

MEDICAL UPDATES

Please list any changes in medications, health status, or hospitalization:

CHANGES

_____ ❑ None _____ (Signature)

_____ _____ (Date Signed)

_____ ❑ None _____ (Signature)

_____ _____ (Date Signed)

_____ ❑ None _____ (Signature)

_____ _____ (Date Signed)

_____ ❑ None _____ (Signature)

_____ _____ (Date Signed)

_____ ❑ None _____ (Signature)

_____ _____ (Date Signed)

MINOR CHILD
TREATMENT RELEASE

I give my permission to Kevin J. Kuffel D.D.S. and/or his designated assistant to perform any and all dental techniques and procedures, including but not limited to the administration of nitrous oxide sedation and anesthetics, on my minor child(ren), _____, whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible for all treatment rendered to the above-named child(ren).

Signed _____ Date _____

PHOTO RELEASE

I give my permission to Kevin J. Kuffel D.D.S. to use my diagnostic photographs, radiographs, and/or study casts in any presentation to any individual or group for purposes of demonstration of dental techniques or facial image, or any other purpose he deems necessary, without recourse or compensation.

Signed _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

To: Kevin J. Kuffel D.D.S. S.C.
1300 S. Calhoun Road
Brookfield, Wisconsin 53005

I hereby give my permission to release to:

Name

Address

City, State, Zip

any information in your possession relating to:

Hospital Treatment _____

Medical Treatment _____

Employment Records _____

Accident Reports _____

(A photocopy of this Authorization shall be considered an original.)

_____ _____
Date Patient's Name

Sworn to before me this _____ day of _____, 19_____

_____
Witness