DENTAL RADIOGRAPH HEALTH HISTORY / AUTHORIZATION

Patient's name: _____ Phone # _____

Address: _____ Birthdate: _____

Date of last dental radiographs (month/year) _____ Approx. how many were taken? _____
Date of last FMX (Full Mouth X-rays = 18 intra-oral x-rays) _____
Have you undergone chemotherapy or radiation treatment? YES NO
If yes, for treatment of what condition? _____
Date of last treatment: _____
Women: Are you pregnant or think you might be? YES NO
Do you wear dental appliances? YES NO Explain: _____
Are you currently under a physician's care? YES NO
If yes please explain: _____

PATIENT AUTHORIZATION:

I hereby authorize an FMX to be taken by the students/faculty of RDA4U and for said radiographs to be released to myself, a dental office, medical office, or governmental agency as requested.

_____ _____
Patient's Signature Date

_____ _____ _____
Print Student Name Student Signature Date

DENTIST AUTHORIZATION:

_____ _____ _____
Authorizing Dentist Name Authorizing Dentist Signature Date

_____ _____ _____
Dentist License # Dentist Address Dentist phone #

Faculty use only:

# of films in survey _____ + # of retakes _____ = # of films exposed _____

Circle All That Apply: Single film / Double film / digital / Pano / BWX / FMX

Faculty Initials: _____