# DENTAL RADIOGRAPH HEALTH HISTORY / AUTHORIZATION

PT'S NAME ________________________________________ Date of Birth ______________________

Minor's Parent's Name _________________________________ Phone Number ______________________

In case of emergency, please call: ___________________________________ Phone #: _______________

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: ____________________________________________________________________

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**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/Parent's Signature Date

__________________________ ______________________________ _____________________

Print Student Name Student Signature Date

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**DENTIST AUTHORIZATION:**

_____________________________ ______________________________ _____________________

Authorizing Dentist Name Authorizing Dentist Signature Date

_____________________________ ______________________________ _____________________

Dentist License # Practice Name / Dentist Address Office phone #

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Faculty use only:

# of films in survey = 18 + ________ retakes = ________ films exposed Pano taken ☐

Patient #: ____________ Date: _________________ Inst. Init.: ___________