



**ROBIN WISE** DDS  
UNDENIABLE SERVICE.  
UNFORGETTABLE SMILES.

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)

\_\_\_\_\_’s  
dental needs.

2. “I authorize the use of radiographs, photographs, or videotapes of my case for use in presentations or publications of the doctor.”

3. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

4. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

Patient’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Responsible Party’s Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**ROBIN WISE, DDS, FAGD**

**428 REMINGTON AVENUE • THOMASVILLE, GA 31792**

**[www.southgeorgiasmiles.com](http://www.southgeorgiasmiles.com)**

# MEDICAL HISTORY

DATE \_\_\_\_\_

Do you have any general health problems?      **YES**      **NO**  
        

If so, please specify \_\_\_\_\_

Are you currently under a physician's care?           

Reason \_\_\_\_\_

Name & Address of Physician:  
\_\_\_\_\_

Are you currently taking any drugs              
or medication?

If so, what? \_\_\_\_\_

To the best of your knowledge, are you or have you ever been  
afflicted with:

Heart Ailment           

Diabetes           

Rheumatic Fever           

Epilepsy           

High Blood Pressure           

Respiratory Disease           

Hepatitis           

Prolonged Bleeding           

Healing Complication           

Allergy to any Drugs           

Would you like us to take your blood pressure?           

Have you ever been told you should take an  
antibiotic before dental treatment for heart  
murmur, heart condition or artificial limbs  
or joints?           

*We would like to get  
to know you better!*

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU?  
\_\_\_\_\_

Person financially responsible for this account  
\_\_\_\_\_

Do you have a dental benefit plan? \_\_\_\_\_

If yes, carrier: \_\_\_\_\_

I hereby grant the right to the dentist and staff to release my dental  
/medical histories and other information about my dental  
treatment to third party payors and/or other health professionals  
by any method, including electronic transfer as deemed necessary  
during my care.

\_\_\_\_\_  
Patient or Responsible Party      Date

## Medical History Review

Notes	Date
_____	_____
_____	_____
_____	_____
_____	_____