# <Medical Analysis Clinical Information Release Consent Form>

| | Y | N | Give Details |
|---|---|---|---|
| 1. Are you pregnant, possibly pregnant, or breastfeeding? | | | |
| 2. Are you currently receiving treatment from a doctor, hospital or clinic? | | | |
| 3. Do you suffer from allergies, including hay fever, eczema, any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods? Or have you got a history of adverse effects to dental materials? Please give details | | | |
| 4. Are you carrying a medical warning card? | | | |
| 5. Do you suffer from bronchitis, asthma or other chest conditions? | | | |
| 6. Do you suffer from fainting attacks, panic attacks, giddiness, blackouts or epilepsy? | | | |
| 7. Do you suffer from heart problems; Have a pacemaker, angina, heart murmur, blood pressure problems or stroke? Have you ever had rheumatic fever? If so, which? | | | |
| 8. Are you diabetic? | | | |
| 9. Do you suffer from arthritis? | | | |
| 10. Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery? | | | |
| 11. Do you suffer from any infectious diseases (including HIV and hepatitis)? | | | |
| 12. Have you ever had liver disease (e.g. Jaundice, hepatitis) or kidney disease? | | | |
| 13. Have you ever had Blood Refused by the Blood Transfusion Service? If so why? | | | |
| 14. Have you ever had a bad reaction to general or local anesthetics? | | | |
| 15. Have you ever had heart surgery or brain surgery? Which? | | | |
| 16. Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jacob Disease (CJD), or received growth hormone treatment before the mid 1980s? | | | |
| 17. Have you ever had radiation therapy to head or neck? | | | |
| 18. Do you have a history of mental health problems? | | | |
| 19. Do you now, or have you ever, suffered from any eating disorders? | | | |
| 20. Do you suffer from Gastro-Oesophageal or Acid Reflux? | | | |
| 21. Any other conditions not listed here? | | | |
| 22. Do you take Bisphosphonate medication for your bones? Have you in the past? Are you likely to in the future (for osteoporosis / steroid use / bone cancer / Padget's disease) | | | |

E line Orthodontics recognizes the patient's right to confidentiality of protected health information as set forth in federal and Texas state law. All releases based on this form are limited to records dated up to and including the date of the patient/responsible party's signature. A new authorization is necessary for release of information on care provided after the date of the patient/responsible party's signature, unless you (the patient or responsible party) state in the authorization to release future records of a specific test, specific clinic appointment, etc.

I, _____, hereby authorize the doctor and staff of E Line Orthodontics to release records or knowledge concerning my dental health to the referring doctor.

Name of Patient _____ Date _____

Name of Guardian if any_____Signature_____