Medical History

Patient Name:	D.O.B.

Please Circle Yes or No for All Questions

- Do you have any medical conditions? Yes No
  * If Yes, please explain:______________________________
- Are you taking any prescription, non-prescription or herbal medications? Yes No
  * If Yes, please list your medications and dosage:______________________________
  ____
- Have you ever had an **adverse reaction** or complication to dental treatment? Yes No
  * If Yes please explain:______________________________
- Do you have an allergy or adverse reaction to any medications? Yes No
  * If Yes, please explain: ______________________________
- Please check the following medications to which you are allergic or have had adverse reactions.
  - ☐ Novocaine, Lidocaine, Articaine, Mepivicaine
  - ☐ Aspirin/non-steroidal anti-inflammatory Meds
  - ☐ Latex
  - ☐ Penicillin or Other Antibiotics _______________
  - ☐ Narcotic Pain Medications (Codeine, Percocet)
  - ☐ Epinephrine (Adrenalin)
- Have you been hospitalized in the past 5 years? Yes No
  * If Yes, please explain:______________________________
- Are you taking, have you ever taken, or will you be taking any osteoporosis/bone loss prevention medications? Yes No
- Do you Smoke or use other Tobacco Products? What/How much? ______________________ Yes No
- Have you ever had an **artificial joint** placed (knee, hip, shoulder, elbow, etc)? Yes No
- Have you ever had infective endocarditis? Yes No
- **Women:**
  * Are you or do you think you could be pregnant? Yes No
  * Are you nursing? Yes No

Please Circle Yes or No to Indicate Which of the Following You Have Had

Condition			Condition		
Heart (Surgery, Disease, Attack, Angina)	Yes	No	Respiratory Disorder or Disease	Yes	No
Heart Murmur	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Artificial Heart Valve	Yes	No	Allergies	Yes	No
Heart Stent	Yes	No	Cancer (type)	Yes	No
Stroke	Yes	No	Liver Disorder or Disease	Yes	No
Blood Pressure (High or Low)	Yes	No	Hepatitis A, B, C (circle)	Yes	No
Arthritis	Yes	No	H.I.V. / A.I.D.S.	Yes	No
Artificial Joints (Hip ,Knee, etc)	Yes	No	Blood Disorder or Disease (Anemia)	Yes	No
Kidney Disorder or Disease	Yes	No	Abnormal Bleeding	Yes	No
Stomach Ulcer	Yes	No	Epilepsy or Seizures	Yes	No
Diabetes Type I or Type II (circle)	Yes	No	Mood Disorders	Yes	No
Thyroid Disorder or Disease	Yes	No	Psychiatric/Psychological Care	Yes	No

Hipaa Acknowledgement

- Do you have or have you had any disease, condition, or problem not listed? ________________________

I understand the above information is necessary to provide me with safe and efficient dental care. Should further information be needed, you have my permission to contact the respective health care provider who may release such information to you. I will notify the doctor or his staff of any changes in my health or medications.

Patient / Guardian Signature____ **Date** ________________________

Dentist Signature ____ Date ________________________

- Do you have any dental problems or concerns? Yes No
  - * If yes, please explain: ____
- Have you ever had a serious injury to your mouth or head? Yes No
  - * If yes please explain: ____
- Do you wear dentures or partials? Yes No
- Are you happy with your smile? Yes No
  - * If not, what would you like to change? ________________________________
- Does food tend to become caught in between your teeth? Yes No
  - * If yes, please explain: ____
- Do you feel nervous about dental treatment? Yes No
  - * If yes, what are your concerns? ____
- Have you ever had an upsetting dental experience? Yes No
  - * If Yes, please explain: ____
- Date of Last Dental Visit ________________
- What was done at your last dental visit? ________________________________
- How often do you have dental examinations? ______________________________
- What do you do every day to care for your teeth, gums and mouth?____________________
- Previous Dentist's Name____
- Address ________________________________ State __________ Zip __________

Are You Experiencing:					
Tooth Sensitivity to Hot or Cold	Yes	No	Clenching, Grinding or Tapping your Teeth while Awake or Asleep	Yes	No
Tooth Sensitivity to Sweets	Yes	No	Clicking or Popping of your Jaw	Yes	No
Tooth Sensitivity to Biting or Chewing	Yes	No	Pain in the Jaw Joint, Ear, or Side of Face	Yes	No
A Sharp, Short-lived Tooth Pain to Chewing "Just the Wrong Way"	Yes	No	Difficulty Opening or Closing your Mouth	Yes	No
Do your gums bleed?	Yes	No	Frequent Headaches	Yes	No
Is your mouth dry?	Yes	No	Frequently Painful Neck and/or Shoulders	Yes	No
Have You Ever Had:					

Patient Information

Orthodontics (Braces) (Retainer)	Yes	No		Periodontal (Gum) Treatment	Yes	No
Oral Surgery (Extractions, Jaw Surgery)	Yes	No		Night Guard or TMJ Treatment Appliance	Yes	No

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, insurance billing, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available upon request.
I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

Patient's Signature ________________________________ Date: ________________

Parent/Responsible Party's Signature ____

Notes:

Patient's Name _________________________________ Prefers to be called? _________________________

Patient's Address _______________________________ City __________________ State ______ Zip _____

Home Phone ___________________________________ Cell Phone: _________________________________

E-mail Address _________________________________ Patient's Birth Date: ____/____/____

Patient's preferred means of contact (circle all that apply) Text Message Email Phone call

Patient's S.S. # _________________________________ Male ☐ Female ☐

Employer_______________________________________ Occupation _________________________________

Business Address ________________________________ City __________________ State ______ Zip _____

Business Phone __________________________________

How did you hear about our dental practice? ____

Dental Insurance Information

Subscriber ______________________________________ Subscriber Birth Date: ____/____/____

Subscriber Relationship to Patient __________________ Insurance Company _________________________

Group # ____ Subscriber I.D.# _____________________________

Subscriber S.S.#_________________________________

Secondary Dental Insurance Information

Subscriber ______________________________________ Subscriber Birth Date: ____/____/____

Hipaa Acknowledgement

Subscriber Relationship to Patient __________________ Insurance Company _________________________

Group # _______________________________________ Subscriber I.D.#____________________________

Subscriber S.S.#________________________________

Person Financially Responsible for the Account

(Leave blank if patient)

Name ____ Birth Date: ____/____/____

Relationship to Patient ___________________________ S.S. # ____________________________________

Address _______________________________________ City __________________ State ______ Zip _____

Home Phone ____________________________________ Cell Phone_________________________________

PRIVACY POLICY

Established to protect the privacy of your health care and personal information. It is our policy to protect your privacy by complying with the HIPAA Privacy Rule.

The HIPAA Privacy Rule establishes a foundation of Federal protection for personal health information, carefully balanced to avoid creating unnecessary barriers to the delivery of quality health care. As such, the Rule generally prohibits a covered entity from using or disclosing protected health information unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities.

Ready access to treatment and efficient payment for health care, both of which require use and disclosure of protected health information, are essential to the effective operation of the health care system. In addition, certain health care operations—such as administrative, financial, legal, and quality improvement activities—conducted by or for health care providers and health plans, are essential to support treatment and payment. Many individuals expect that their health information will be used and disclosed as necessary to treat them, bill for treatment, and, to some extent, operate the covered entity's health care business. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities.

The minimum necessary standard, a key protection of the HIPAA Privacy Rule, is derived from confidentiality codes and practices in common use today. It is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as

Patient Information

needed to limit unnecessary or inappropriate access to and disclosure of protected health information. The Privacy Rule's requirements for minimum necessary are designed to be sufficiently flexible to accommodate the various circumstances of any covered entity.

I give permission to discuss my dental treatment with the following individual(s): Please list name and relation

____

____

I have been informed of this policy and have been offered a written copy.

Name____

Signature____ Date______________