Medical and Dental Health History Form

Our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only, will never be used to discriminate, and will be kept confidential subject to applicable laws. If you have any questions or are unsure how to answer a question, we'd be happy to assist you - please ask!

First name: _____ Last name: _____
Gender: _____ Date of Birth: _____ SSN # or Patient ID: _____
Insurance Company:_____/_____ Employer:_____
If completing this form for someone, your name/relationship: _____/_____
Name of previous dentist/location: _____
Date of last dental exam/x-rays: _____ Last cleaning: _____
Name/Phone of Family Physician: _____ / (_____)_____-_____

DENTAL HEALTH:

CHECK ALL THAT APPLY

- ❑ Are you having any **pain** or **discomfort** at this time?
- ❑ Do your **gums bleed** while brushing and flossing?
- ❑ Are your **teeth sensitive** to hot or cold liquids/foods?
- ❑ Do you have any concerns about **bad breath**?
- ❑ Does **food/floss catch** between your teeth?
- ❑ Do you have **sores or ulcers** in your mouth?
- ❑ Do you have a **dry mouth**? If so, do you know why:_____
- ❑ Have you ever experienced any problems with your **jaw**?
- ❑ Do you have frequent **headaches**?
- ❑ Do you **clench or grind** your teeth? Daytime:_____ Nighttime:_____ ; Do you have a nightguard? _____
- ❑ Have you ever had any **periodontal (gum) surgery** or **deep cleanings**? Approximately when:_____
- ❑ Have you ever had any **orthodontic** treatment? Do you wear a retainer?_____
- ❑ Have you ever had **facial or oral surgery**? (ex. wisdom tooth removal? When:_____
- ❑ Have you ever had any type of **trauma** to your mouth, jaw or face?

  Area: _____When:_____

MEDICAL HEALTH:

Are you ALLERGIC to or had a bad reaction to any of the following (check all that apply)**:**

- ❑ Acetaminophen
- ❑ Aspirin
- ❑ Codeine/Narcotics
- ❑ **Ibuprofen**
- ❑ Nitrous Oxide
- ❑ **Local Anesthesia**
- ❑ **Penicillin**
- ❑ Erythromycin
- ❑ Tetracycline
- ❑ Other antibiotics
- ❑ Latex
- ❑ Metals or Plastic
- ❑ Sulfa Drugs, Sulfites, Sulfides
- ❑Barbiturates, Sedatives, Sleeping Pills
- ❑Other: _____

Are you seeing a **PHYSICIAN** regularly? If so, what for what condition?
___Regular Physical ***or:***_____

ANTIBIOTIC PREMEDICATION: *The recent guidelines from the ADA and AHA recommend premedication for patients with the following **only**. If you have none of the issues and your surgeon recommends antibiotics for life, we have paperwork you can review and we request them to prescribe for you. If you have checked one, we will prescribe antibiotics for you.*

- ❑Prosthetic heart valve
- ❑Prosthetic material for heart valve repair
- ❑Heart transplant with valve regurgitation
- ❑Unrepaired cyanotic congenital heart disease (including palliative shunts/ conduits)
- ❑History of infective endocarditis
- ❑Repaired congenital heart defect with residual shunts or valvular regurgitation

Check off any of the following MEDICAL CONDITIONS that you had or have at the present:

❑**Asthma**:
- ❑Inhaler? _____
- What causes attacks? _____

❑**Heart disease** or **heart attack**:
- Date: _____

❑**Stroke:** Date _____
❑**Diabetes**: Type I _____ Type II _____
❑**Seizures** ____ **Epilepsy** ____
❑Infectious disease:
- ❑Infectious mononucleosis (mono)
- ❑HPV
- ❑Hepatitis A___ B ___ C ___
- ❑AIDS ___ HIV+ ___
- ❑Herpes

❑**Bisphosphonate** therapy for osteoporosis/Paget's etc. (e.g. Boniva, Fosamax, etc.)
❑Heart pacemaker: Date_____
❑Heart surgery: Date_____
❑High **Blood Pressure**
❑Low **Blood Pressure**
❑Kidney disease
❑Bleeding disorders
❑Arthritis
❑Hypothyroidism
❑Hyperthyroidism
❑Cancer:_____
❑Radiation: _____
❑Chemotherapy: _____
❑Tumor or malignancy
❑Psychiatric treatment
❑Tuberculosis or lung disease Liver disease
❑Rheumatic fever
❑Heart murmur/mitral valve prolapse
❑Drug addiction (or history of)
❑Alcoholism (or history of)
❑Blood transfusion
❑Sickle cell disease/traits
❑Anemia
❑Hemophilia
❑Hay fever
❑Ulcers
❑Jaundice
❑Headaches
❑Shingles
❑Osteoporosis
❑Sinus issues
❑Anaphylaxis
❑Fainting
❑Glaucoma
❑Artificial joints
❑Hard of hearing
❑Autoimmune disease
❑Sleep disorder

MEDICATIONS (prescription, over-the-counter, vitamins, herbs, and supplements)**:** *(If there are too many to list, we can make a copy of your medication list to keep with your file)*

Name	***Dose (mg)***	***# Times Taken***	***When (2x/day, etc.)***

MAJOR SURGERIES OR HOSPITAL VISITS (Type and Year):

_____
_____
_____
_____
_____

Do you have any disease, condition or problem that **WAS NOT LISTED**?

_____
_____

SOCIAL HISTORY: (Check all that apply)

❑Do you use any form of tobacco? (cigarettes/cigars, vaping, chewing)
❑Do you use any kind of recreational drugs:_____
❑Do you drink alcohol? How often:_____ How many drinks:_____
❑Are you pregnant? If yes, due date: _____
❑Could you be pregnant?
❑Are you nursing?
❑Are you taking hormone replacements? Which one(s): _____

In the event of an EMERGENCY please contact:

Name: _____ Relationship: _____ Phone: _____

FINANCIAL AND CANCELLATION POLICY:

1. I understand that my payment portion is due in full on, or before, the date of my appointment: _____ (Initial here)

2. I understand that I will need to call to cancel an appointment at least 1 business day in advance so that other patients who need to be seen are not postponed needlessly: _____ (Initial here)

3. I understand that a $50 cancellation fee will need to be collected from me before another appointment can be booked if I cancel with less than 1 business day's notice*: _____ (Initial here)

**True emergencies will not be subject to the cancellation fee but, if repeatedly missing appointments at the last minute, pre-reserved appointments may not be offered.*

4. If I have multiple last minute cancellations, I understand that time cannot continue to be reserved for me. I may be dismissed as a patient, or can only be booked only same-day, whenever there is availability: _____ (Initial here)

5. I authorize payment of dental benefits to myself or the office for professional services rendered and release of any information needed to process my claims: _____ (Sign here)

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (name) _____, have reviewed a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Name_____ Signature _____ Date _____

Note: *If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information.*

Right to Revoke*: You have the right to revoke this consent at any time by giving us written notice of your revocation. Revocation will not affect any action we took in reliance on this consent before we received your revocation. Please understand that revocation may make thorough treatment difficult and we may decline to treat you or to continue treating you if you revoke this consent.*

FINAL REVIEW OF FORM

Authorization: I have reviewed the information on this form, understood it, and it is accurate to the best of my knowledge. I understand that this information will be relied upon by the dentist and staff to help determine appropriate and healthful dental treatment. I acknowledge that my questions, if any, about inquiries have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If there is any change in my medical status I will inform the dentist.

Printed Name of Patient_____/Legal Guardian:_____

Signed: _____ Date: _____

Doctor Reviewed: _____ Date: _____

THANK YOU FOR COMPLETING OUR FORM!

Patient Yearly Review and Update of Form:

Date	*I have reviewed the attached Health History Form. My health and medications have changed as follows: (If no changes, write "No change")*	*Patient's Signature*	*Witness Signature*