

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / / What was done at that appointment?			
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth?	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>
Does it hurt to chew, bite or swallow?	<input type="checkbox"/>	If yes, please describe what happened and when it happened: _____	
Do your gums bleed when you brush or floss your teeth?	<input type="checkbox"/>	Have you ever had problems with dental treatment in the past?	<input type="checkbox"/>
Have you ever had periodontal (gum) treatments like scaling and root planing?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Do you have, or have you ever had, any sores or growths in your mouth?	<input type="checkbox"/>	Have you ever had a reaction to, or problem with, dental anesthesia?	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Does your jaw click, pop or hurt?	<input type="checkbox"/>	Are you unhappy with your smile?	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	If yes, why? Please mark all that apply:	
Does dental treatment make you nervous?	<input type="checkbox"/>	<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders?	<input type="checkbox"/>	<input type="checkbox"/> Other. Please describe: _____	
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep			
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			Yes No ?
Are you taking any blood thinners (such as Coumadin, Warfarin, Xarelto®, dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use vaping products ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pregnant ? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nursing ? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes No ?	Yes No ?
Aspirin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix).....
Barbiturates, sedatives or sleeping pills.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other
Hay fever/seasonal allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Iodine.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience.
Latex (rubber)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Local anesthetics.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Metals	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)?

Doctor's Name: Phone:

Please use an "X" to mark your answers to the following questions.

Are you in good physical health?

Are you currently being seen or treated by a physician?

Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?

Have you had a **serious illness, operation or been hospitalized** in the past 5 years?

Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?

Have you had a **heart valve replacement or heart surgery**?

Have you had an **organ or bone marrow/stem cell transplant**?

Have you traveled internationally within the last 30 days.....

Have you had a fever (100.4°F or above) in the last 72 hours?

If you answered yes to any of the above, please explain:

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

Heart (Cardiac) Health	Yes No ?	Cancer	Yes No ?	Digestive Health	Yes No ?
Pacemaker/implanted defibrillator	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Artificial (prosthetic) heart valve	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of diagnosis:		G.E. reflux/persistent heartburn (GERD).....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chemotherapy:		Stomach ulcers.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Radiation treatment:		Eye (Vision) Health	
Unrepaired, cyanotic CHD.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Glaucoma.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood (Circulatory) Health		Other	
Repaired CHD with residual defects	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date:		Diabetes (type I or II)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	High or low blood pressure.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Brain (Neurological)/Mental Health		Type of infection:	
Heart murmur/rhythm disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anxiety.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Immune deficiency.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Stroke.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Breathing (Respiratory) Health		Mental health disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma (COPD)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Post-traumatic stress disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Emphysema.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Traumatic brain injury or concussion.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted infection (STI).....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sinus trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune Disease		Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
		Lupus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

Do you have any disease, condition, or problem that's not listed here? If so, please explain:

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes No ?	Yes No ?	Yes No ?
had pain or tightness in the chest?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
been exposed to anyone with tuberculosis?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
had a rapid or irregular heart beat?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	fainted for no reason?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			experienced vomiting, diarrhea, chills, night sweats or bleeding?.....
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			had migraines or severe headaches?
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments:

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service, and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the Doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request a change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

ACKNOWLEDGEMENT

I, _____ (patient name), do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this date forward.

Signed _____ Dated _____