



MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

- Are you allergic to any of the following?
Aspirin, Penicillin, Codeine, Local Anesthetics, Acrylic, Metal, Latex, Sulfa drugs, Other

- Do you have, or have you had, any of the following?
AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above?

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

<b>Please check any of the following problems that apply to you.</b>				<b>If you could whiten your teeth for a cost anyone could afford, would you do it?</b>		
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL				<b>Do you smoke or use chewing tobacco?</b> How much? For how long?		
-Headaches, earaches, neck pain				<b>If I could change my smile, I would:</b>		
-Jaw joint pain				-Make them whiter		
-Teeth or fillings breaking				-Make them straighter		
-Grinding or clenching teeth				-Close spaces		
-Bleeding, swollen or irritated gums				-Replace black metal fillings with tooth colored restorations		
-Loose, tipped or shifting teeth				-Repair chipped teeth		
-Bad breath				-Replace missing teeth		
<b>Do you have or have you had any of the following?</b>				-Replace old crowns that don't match		
-Dentures				-Have a smile makeover		
-Partial dentures				<b>On a scale of 1 – 10, with 10 being the highest rating:</b>		
-Braces				-How important is your dental health to you?		
-Periodontal (gum) treatments				1 2 3 4 5 6 7 8 9 10		
<b>Please share the following dates:</b>				-Where would you rate your current dental health?		
-Your last cleaning			___ / ___	1 2 3 4 5 6 7 8 9 10		
-Your last oral cancer screening			___ / ___	-Where do you want your dental health to be?		
-Your last complete X-Rays			___ / ___	1 2 3 4 5 6 7 8 9 10		
<b>Name of Previous Dentist</b> _____						
<b>City</b> _____ <b>State</b> _____				<b>Why did you leave your previous dentist?</b>		
<b>Phone Number</b> _____						
<b>What is the most important thing to you about your future smile and dental health?</b>				<b>What is the most important thing to you about your dental visit today?</b>		

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

**Are you taking any of these medications?**

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin?			When did the treatment end?	No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_  
 Home Address \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Number (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Pager #(\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_

Employer Name and Address \_\_\_\_\_  
 Occupation \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_  
 Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Home # \_\_\_\_\_  
 Home Address (if different) \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer and address \_\_\_\_\_  
 Occupation \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_  
 Referred By \_\_\_\_\_ Physician \_\_\_\_\_

Emergency Information Name, address, telephone of a relative not living with you: \_\_\_\_\_

DENTAL INSURANCE INFORMATION (Primary)		SECONDARY INSURANCE INFORMATION	
Insured's Name:		Insured's Name:	
Insured's DOB:		Insured's DOB:	
Insured's Employer:		Insured's Employer:	
Insurance Company:		Insurance Company:	
Group#	Phone#	Group#	Phone#

## FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

### *Do You Have Insurance?*

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependants is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance.

Patient Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's  
Notice of  
Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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## For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Our prescriptions are sent electronically due to changes in Federal Drug Regulations.  
For that reason we need the following information:

Patient's Name \_\_\_\_\_

PHARMACY INFORMATION

Pharmacy Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_