❺ *Medical History.* Patient name _____ Birth date _____ Today's date _____

Date of last dental visit _____ Date of last xrays _____

Type of cleaning done: ☐ deep ☐ regular Is there any pending treatment that was proposed by your last dentist? ☐ Yes ☐ No

Reason for leaving previous dentist?_____

Are you aware of any jaw pains or clenching/grinding? ☐ Yes ☐ No Your height _____ Your weight _____

Any dental complaints/concerns you would like to be addressed today? _____

_____

Are you happy about your smile? ☐ Yes ☐ No If no, what would you like to change? _____

_____

Are you under the care of a doctor? ☐ Yes ☐ No If yes, what condition(s) are you being treated for? _____

_____

Doctor's name _____ Phone (_____)_____ Fax (_____)_____

Date of last physical _____ Previous hospitalizations _____

_____

Complications from any medical problems or hospitalizations _____

Have you ever had any of the following? *check all that apply*

- ☐ Allergies
- ☐ Arthritis or Rheumatism
- ☐ Artificial Heart Valves, Screws, etc.
- ☐ Infective Endocarditis
- ☐ Cardiac Transplant
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency/ Recreational Drug Abuse
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone-Steroid Treatment
- ☐ Diabetes
- ☐ Epilepsy, Convulsions or Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Hernia Repair_____
- ☐ Infectious Disease
- ☐ Kidney or bladder Disease
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss _____
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems/Hayfever
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Swollen Ankles
- ☐ Thyroid Trouble
- ☐ Ulcer
- ☐ Sexually Transmitted Disease
- ☐ Fainting
- ☐ Sleep Apnea
- ☐ Tobacco Use (smoking or dip)
- ☐ History of HPV (Human Papillomavirus)
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Family History of Diabetes, Heart Disease, or Stroke

Has your doctor ever told you that you need to take antibiotic premedication prior to any dental appointment or procedure? (This is usually due to having had joint replacement, heart surgery, chemotherapy, etc.) ☐ Yes ☐ No If yes, explain. _____

_____

Please list all prescription and over-the-counter medications you are currently taking and the reasons you take them. *(Attach list if needed)*

_____

Allergies. Do you have any drug allergies or have you ever had an adverse reaction to any medication, anesthetic, materials, or latex?
☐ Yes ☐ No If yes, what do you react to? _____

For women. Are you pregnant, or do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____
Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Medical History. *(cont.)* Patient name _____ Birth date _____ Today's date _____

Do you have any disease or condition not listed on the previous page, or anything about your health problem that we have not covered?

☐ Yes ☐ No If yes, please explain. _____

Is there anything else we should know about your medical history? _____

_____

❻ *Emergency Contact Information.* Please list the names and telephone numbers of two relatives (or friends) not living with you that we may contact in the case of an emergency.

Name _____ Relationship _____ Phone (_____)_____

Address _____

Name _____ Relationship _____ Phone (_____)_____

Address _____

❼ *Release.* I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

X _____

Signature *Date*

❽ *Health Information Authorization.* I AUTHORIZE THE DENTAL OFFICE TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING PERSONS:

Name _____ Relationship _____ Phone (_____)_____

Name _____ Relationship _____ Phone (_____)_____

Name _____ Relationship _____ Phone (_____)_____

❾ *HIPAA Release (Privacy Practices Documentation).* I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

_____

Patient Name (please print) *Patient Birth Date*

X _____

Signature *Date*

To Be Completed by Front Office

Written acknowledgement could not be documented due to the following reason(s):

- ☐ patient refusal to sign
- ☐ personal representative not available to sign
- ☐ language, communication, or effects of disability impeded acknowledgement
- ☐ emergency care impeded acknowledgement
- ☐ other, please specify_____