Date_____

MEDICAL HISTORY FORM

Patient Information:

Patient's Name:_____
Last First Middle Initial

Address: _____
Address City State Zip Code

Email Address: _____ SSN:_____ - ____ - _____ Date of Birth: _____/_____ / ____ Age: _____

Sex: ☐ M ☐ F Home No: _____ Cell No: _____ Alt. No: _____

Parent/Guardian Insurance Information: *Relationship to Patient:* _____ ☐ SELF

Name: _____
Last First Middle Initial

SSN:_____ - _____-_____ Insurance No.: _____ Driver License No.:_____

Date of Birth: _____ / ____ / _____ Insurance Telephone No.: _____ Group No.: _____
Employer: _____ Address: _____
Home No: _____ Cell No: _____ Work No: _____
Name and Number of nearest relative not living with you: _____

How did you hear about us? Please mark below:

☐ Online ☐ Flyer / Mail ☐ Printed Ad ☐ Billboard
☐ Radio ☐ TV ☐ Community Event ☐ Health Fair / Screening
☐ Dr. Referral ☐ Driving / Walking by the Office ☐ Medicaid ☐ Insurance / Employer
☐ Friend / Relative ☐ Employee ☐ Other (Specify) _____

Reason for today's dental visit: _____Date of last dental visit: _____
Have you ever had an experience in a dental office that you would like to tell us about? ☐ **Yes** ☐ **No**
Please explain if yes:_____

Are you nervous about dental treatment? ☐ **Yes** ☐ **No**
Do your gums bleed, feel tender or irritated? ☐ **Yes** ☐ **No**
Are you unhappy with appearance of your teeth? ☐ **Yes** ☐ **No**
Are your teeth sensitive? ☐ **Yes** ☐ **No**
Do you have discolored teeth that bother you? ☐ **Yes** ☐ **No**
If yes, to what? ☐ **Sweets** ☐ **Hot** ☐ **Cold** ☐ **Pressure**
Are you now seeing a physician? ☐ **Yes** ☐ **No** The name & telephone number of your physician(s)_____
If so, what is the condition being treated? _____
Are you taking any medications? ☐ **Yes** ☐ **No** If yes, please list: _____
Have you or are you currently taking Aspirin? ☐ **Yes** ☐ **No**
If female, are you or do you suspect to be pregnant? ☐ **Yes** ☐ **No** Months: _____
Have you or are you currently taking oral Bisphosphates? ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Skelif ☐ Didrone ☐ Other _____
Have you had any joint replacements? ☐ **Yes** ☐ **No** If yes, when? _____
Is there anything else we should know about your health that was not covered on this form? ☐ **Yes** ☐ **No**
If yes, Please explain: _____

Please mark any of the following which you have had or have at present: ☐ NONE

☐ Heart Disease ☐ Anemia ☐ Nervousness ☐ HIV + AIDS
☐ Heart Murmur ☐ Kidney Trouble ☐ Thyroid Disease ☐ Hepatitis
☐ High Blood Pressure ☐ Bone Loss ☐ Chemo: (Cancer, Leukemia) ☐ Hemophilia
☐ Blood Disease ☐ Epilepsy or Seizures ☐ Arthritis ☐ Sickle Cell Disease
☐ Rheumatic Fever ☐ Ulcers ☐ Rheumatism ☐ Bruise Easily
☐ Venereal Disease ☐ Emphysema ☐ Cortisone Medicine ☐ Pain in Jaw Joint
☐ Heart Pacemaker ☐ Tuberculosis ☐ Joint Replacement ☐ Diabetes
☐ Asthma ☐ Scarlet Fever ☐ Hay Fever ☐ Glaucoma

Please mark any of the following medical allergies: ☐ NONE

☐ Local Anesthetics ☐ Penicillin ☐ Codeine or other narcotics ☐ Fen-Phen
☐ Aspirin ☐ Other antibiotic: ☐ Barbiturates or sedatives ☐ Other: _____
☐ Iodine ☐ Sulfa Drugs ☐ Latex ☐ Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.

_____
Signature of Patient/Parent/Guardian

Medical History Update:

Dr. Date Dr. Date Dr. Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.

Please list all telephone numbers where we may contact you:

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, PARENTS, GRANDPARENTS, ETC...) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice. I further understand that the practice will offer me updated to this Notice of Privacy Practice. Should it be amended, modified or changed in any way I will receive a copy.

_____

Printed Name of Patient

_____

Signature of Patient/Parent/Guardian

FOR OFFICE USE ONLY

❑Patient refused to sign

❑Patient was unable to sign because: _____

Date: _____Signature:_____