Health History Form

E-mail

Today's Date

As required by law, 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 and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PERSONAL INFORMATION

First Name

Last Name

MI

Home Phone

Cell Phone

Work Phone

Prefered Method of Contact

Phone Text Email

Mailing Address

City

State

Zip

Height

Weight

Date of Birth

Sex

Occupation

Emergency Contact

How did you hear about us?

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

Home Phone

Cell Phone

DENTAL INFORMATION *For the following questions mark (x) your responses*

	Yes	No
Are your teeth sensitive to cold, hot, sweets or pressure?	○	○
Does food or floss catch between your teeth?	○	○
Is your mouth dry?	○	○
Have you had any periodontal (gum) treatments?	○	○
Have you ever had orthodontic (braces) treatment?	○	○
Have you ever had any problems associated with previous dental treatment?	○	○
Is your home water supply fluoridated?	○	○
Do you drink bottled or filtered water?	○	○

If yes, how often?

○DAILY ○WEEKLY ○OCCASIONALLY

	Yes	No
Are you currently experiencing dental pain or discomfort?	○	○

Chief Complaint

	Yes	No
Do you have earaches or neck pains?	○	○
Do you have any clicking, popping, or discomfort in the jaw?	○	○
Do you brux or grind your teeth?	○	○
Do you have sores or ulcers in your mouth?	○	○
Do you wear dentures or partials?	○	○
Do you participate in active recreational activities?	○	○
Have you ever had a serious injury to your head or mouth?	○	○

Date of your last exam

What was done at that time?

Date of last dental x-rays

Reason for visit

MEDICAL INFORMATION

For the following questions, please mark (X) your responses.

Are you currently under the care of a physician? Yes ○ No ○

Physician Name

Phone

Address/City/State/Zip

Are you in good health? Yes ○ No ○

Has there been any change in your general health within the past year? Yes ○ No ○

If yes, what condition is being treated?

Date of last physical exam

Do you have a history of chemical dependency? Yes ○ No ○

For the following questions mark (x) your responses

Yes No

Do you use controlled substances (drugs)? ○ ○

Do you use tobacco (smoking, snuff, chew, bidis)? ○ ○

If so, how interested are you in stopping?

○ VERY ○ SOMEWHAT ○ NOT INTERESTED

Do you drink alcoholic beverages? Yes ○ No ○

If yes, how much alcohol did you drink in the last 24 hours?

WOMEN ONLY Are you: Yes No

Pregnant? ○ ○

Number of weeks

Taking birth control pills or hormonal replacements? ○ ○

Nursing? ○ ○

Are you in recovery? Yes ○ No ○

If yes, how long have you been in recovery?

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes ○ No ○

If yes, what was the illness or problem?

Do you take any blood thinners? Yes ○ No ○

Do you take aspirin on a regular basis? Yes ○ No ○

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes ○ No ○

If yes, please list all medications, including vitamins, natural or herbal preparations and/or diet supplements:

Joint Replacement: Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ○ No ○

If yes, date

If yes, have you had any complications?

MEDICAL INFORMATION *(Continued)*

Allergies: Are you allergic or have you had a reaction to:

	Yes	No		Yes	No
Local anesthetics	○	○	Latex (rubber)	○	○
Aspirin	○	○	Iodine	○	○
Penicillin or other antibiotics	○	○	Hay fever/seasonal	○	○
Barbiturates, sedatives, or sleeping pills	○	○	Animals	○	○
Sulfa drugs	○	○	Food/Other	○	○
Codeine or other narcotics	○	○	If yes, please specify		
Metals	○	○			

Please mark (X) your response if you have or have had any of the following diseases or problems.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart murmur	○	○	Blood transfusion	○	○	Diabetes type I or type II	○	○	Mental health disorders	○	○
Mitral valve prolapse	○	○	If yes, date			Eating disorder	○	○	If yes, please specify		
Artificial heart valves	○	○				Malnutrition	○	○			
Rheumatic fever	○	○	Hemophilia	○	○	Gastrointestinal disease	○	○	Recurrent infections	○	○
Cardiovascular disease	○	○	AIDS or HIV infection	○	○	GE Reflux/persistent heartburn	○	○	If yes, type of infection		
Angina	○	○	Arthritis	○	○	Ulcers	○	○			
Arteriosclerosis	○	○	Autoimmune disease	○	○	Thyroid problems	○	○	Kidney problems	○	○
Congestive heart failure	○	○	Rheumatoid arthritis	○	○	Stroke	○	○	Night sweats	○	○
Coronary artery disease	○	○	Systematic lupus erythematosus	○	○	Glaucoma	○	○	Osteoporosis	○	○
Damaged heart valves	○	○	Asthma	○	○	Hepatitis, jaundice, or liver disease	○	○	Persistent swollen glands in neck	○	○
Heart attack	○	○	Bronchitis	○	○	Epilepsy	○	○	Severe headache/migraines	○	○
Low blood pressure	○	○	Emphysema	○	○	Fainting spells/seizures	○	○	Severe/rapid weight loss	○	○
High blood pressure	○	○	Sinus trouble	○	○	Neurological disorders	○	○	STDs/STIs	○	○
Congenital heart defects	○	○	Tuberculosis	○	○	If yes, please specify			Excessive urination	○	○
Pacemaker	○	○	Cancer/Chemotherapy/ Radiation treatment	○	○				ADD	○	○
Rheumatic heart disease	○	○							ADHD	○	○
Abnormal bleeding	○	○	Chest pain upon exertion	○	○	Gag Reflex Sensitivity	○	○	Sensory Processing Disorder	○	○
Anemia	○	○	Chronic pain	○	○	Sleep disorder	○	○	Oral Sensory Sensitivity	○	○

	Yes	No
Has a physician recommended that you take antibiotics prior to your treatment?	○	○
Do you have any disease, condition, or problem not listed above that you think I should know about?	○	○

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their 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.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

FOR COMPLETION BY OFFICE

Comments:

Insurance Form

GENERAL INFORMATION

Patient Name

Date of Birth

PRIMARY DENTAL INSURANCE

Policy Holder

Self Other

Policy Holder Name (if not patient)

Relationship to Patient

Self Spouse Parent Legal Guardian Partner Other

If other, please specify

Name of Employer

Work Phone

Address of Employer

City

State

Zip

Policy Holder Date of Birth

Insurance Company

Insurance Group #

Insurance Plan #

Effective Date

SECONDARY DENTAL INSURANCE

Policy Holder

Self Other

Policy Holder Name (if not patient)

Relationship to Patient

Self Spouse Parent Legal Guardian Partner Other

If other, please specify

Name of Employer

Work Phone

Address of Employer

City

State

Zip

Policy Holder Date of Birth

Insurance Company

Insurance Group #

Insurance Plan #

Effective Date

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

If I am entitled to benefits under Medicare, Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration of services provided to me, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of these benefits directly, with such benefits being applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment, and any charges for service deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance plan.

Initial

☐ I give my consent for examination and treatment.

Initial

☐ I authorize the release of information including the diagnosis, records, examination, treatment, radiology, and claims of information.

This information may be released to

☐ Spouse ☐ Family ☐ Friend ☐ Other Treating Physician(s) ☐ Do Not Release my Medical Information

SIGNATURE

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Patient Screening Form

Patient Name

	Pre-Appointment		In-Office	
	Date		Date	
PATIENT SCREENING				
Have you/they recently been vaccinated for COVID-19?	Yes	No	Yes	No
Have you/they recently received a booster shot for COVID-19?	Yes	No	Yes	No
If yes, when was your/their last shot? Which vaccination did you/they receive?				
Have you/they recently been tested for COVID-19?	Yes	No	Yes	No
If yes, please specify test date				
Have you/they tested positive for COVID-19?	Yes	No	Yes	No
If yes, please specify the date of your/their positive test result.				
Within the past 14 days, have you/they had a known exposure to any individual suspected or confirmed to have COVID-19 or who has traveled to a location after which self-quarantine is recommended? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	Yes	No	Yes	No
Is your/their age over 60?	Yes	No	Yes	No
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder?	Yes	No	Yes	No
WITHIN THE PAST 24 HOURS, HAVE YOU/THEY HAD ANY OF THE FOLLOWING SYMPTOMS?				
Fever or chills	Yes	No	Yes	No
Cough	Yes	No	Yes	No
Shortness of breath or difficulty breathing	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Muscle or body aches	Yes	No	Yes	No
Headaches	Yes	No	Yes	No
New loss of taste or smell	Yes	No	Yes	No
Sore throat	Yes	No	Yes	No
Congestion or runny nose	Yes	No	Yes	No
Nausea or vomiting	Yes	No	Yes	No
Diarrhea	Yes	No	Yes	No

SIGNATURE

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Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian Date

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HIPAA Consent Form

GENERAL INFORMATION

Name

Date of Birth

Street Address

City

State

Zip

CONSENT & NOTICE OF PRIVACY PRACTICES *Please read the following statements carefully.*

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. 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 that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us by phone or email.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I have had full opportunity to read and consider the contents of this Consent & Notice of Privacy Practices. 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 health care operations.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

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