

# MEDICAL HISTORY FORM

Date \_\_\_\_\_

## 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:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Online            | <input type="checkbox"/> Flyer / Mail                    | <input type="checkbox"/> Printed Ad            | <input type="checkbox"/> Billboard               |
| <input type="checkbox"/> Radio             | <input type="checkbox"/> TV                              | <input type="checkbox"/> Community Event       | <input type="checkbox"/> Health Fair / Screening |
| <input type="checkbox"/> Dr. Referral      | <input type="checkbox"/> Driving / Walking by the Office | <input type="checkbox"/> Medicaid              | <input type="checkbox"/> Insurance / Employer    |
| <input type="checkbox"/> Friend / Relative | <input type="checkbox"/> Employee                        | <input type="checkbox"/> 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:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Nervousness               | <input type="checkbox"/> NONE                |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Kidney Trouble       | <input type="checkbox"/> Thyroid Disease           | <input type="checkbox"/> HIV + AIDS          |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone Loss            | <input type="checkbox"/> Chemo: (Cancer, Leukemia) | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Hemophilia          |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Rheumatism                | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Bruise Easily       |
| <input type="checkbox"/> Heart Pacemaker     | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Joint Replacement         | <input type="checkbox"/> Pain in Jaw Joint   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Scarlet Fever        | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Diabetes            |

## Please mark any of the following medical allergies:

- |  |  |   |                                       |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Fen-Phen     |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Other antibiotic: | <input type="checkbox"/> Barbiturates or sedatives  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Iodine            | <input type="checkbox"/> Sulfa Drugs       | <input type="checkbox"/> Latex                      | <input type="checkbox"/> 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: \_\_\_\_\_