ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐
If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).
If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐
If yes, please list them here and include information about how much and how often you use each one. _____

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐

Nursing? If yes, number of weeks: _____ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐

	Yes	No	?
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5°F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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GREENE COMPREHENSIVE FAMILY DENTISTRY

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law.
You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice is a member of statewide Prescription Monitoring Program.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

I give my permission to discuss my treatment and or billing information with: _____

Relationship to patient (check one):

❸ Spouse ❸ Parent ❸ Child ❸ Grandparent ❸ Grandchild ❸ Legal Guardian

❸ Attorney (or representative) of patient ❸ Other: _____

This HIPAA Consent was signed by: _____ _____

Signature of patient or guardian — Printed name of same

Relationship to the patient (if other than patient): _____ _____

Please print — Today's Date

GREENE COMPREHENSIVE FAMILY DENTISTRY

PATIENT FINANCIAL RESPONSIBILITY

I _____ hereby assign to Greene Comprehensive Family Dentistry all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge that any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Greene Comprehensive Family Dentistry thereafter receives payment from my insurance company, I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s), my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

This office participates as "Dental Providers" for **Anthem, Cigna Radius, Delta Dental Premier, Guardian, MetLife** and **United Concordia.** If you have dental insurance with companies other than those listed above, you will be responsible for your co-payment **TODAY** according to your dental insurance plan. We will submit today's visit to your insurance company. Also that all estimates for co-payment are **estimates** you are responsible for what your insurance does not pay.

- I agree to pay interest on the total paid monthly balance at the rate of **18.00% APR**, such interest to begin if the **account is thirty (30) days past due** and calculated from the date of service.
- I agree to pay all costs of collections, including, but not limited to, thirty-five percent (35%) collection fees and attorney fees of thirty-three percent (33%), but not less than $200.00, regardless if suit is filed or not, as well as, all court costs.
- I authorize my employer to release all information regarding employment and salary verification.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept postdated checks.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept payment plans and payment is expected at every appointment unless otherwise stated.
- Broken, missed, or canceled appointments without 24 hours prior notification will be charged a missed appointment fee of $75.00.
- **I will pay any expected deductible and co-insurance amounts today and at each future office visit.**

We are a medical practice and as such we will ask you to complete a Health History Form. We will ask you for updates of your personal and medical information. Please notify our staff if there is a change in your health. Your health information is important to us and to your treatment here. Your cooperation in completing this information is appreciated.

THERE WILL BE A FEE OF $35.00 FOR ALL RETURNED CHECKS

_____ _____ _____

Print Name (Patient) Signature of Responsible Party Date