Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

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.

PATIENT INFORMATION

Patient Name:
Date of Birth:
Gender:
Social Security Number:
Primary Phone Number:
Email Address:

EMERGENCY CONTACT INFORMATION

REFERRAL SOURCE

How did you hear about our office?
If applicable, provide the name of who we can thank:

Pharmacy Information

Do you have a preferred pharmacy that you would like us to keep on file? Yes [ ] No [ ]
Pharmacy Name

DENTAL INFORMATION

DENTAL HEALTH

PLEASE SELECT YES OR NO TO THE FOLLOWING DENTAL HEALTH QUESTIONS:

Do you have any immediate dental concerns?	Yes [ ]	No [ ]	Are you currently experiencing dental pain or discomfort?	Yes [ ]	No [ ]
Have you had any problems with previous dental treatment?	Yes [ ]	No [ ]	Have you ever had a serious injury to your head or mouth?	Yes [ ]	No [ ]
Have you ever had teeth become loose, without injury?	Yes [ ]	No [ ]	Have you had any periodontal (gum) treatments?	Yes [ ]	No [ ]
Do your gums bleed when you brush or floss?.	Yes [ ]	No [ ]	Have you had any cavities in the last 3 years?	Yes [ ]	No [ ]
Are your teeth sensitive to cold, hot, sweets or pressure?.	Yes [ ]	No [ ]	Do you ever have times your mouth feels dry?	Yes [ ]	No [ ]
Do you brux, grind, or clench your teeth?	Yes [ ]	No [ ]	Do you have earaches or neck pains?	Yes [ ]	No [ ]
Do you have any clicking, popping or discomfort in the jaw?	Yes [ ]	No [ ]	Have your teeth become shorter, thinner, or worn in the last 5 years?	Yes [ ]	No [ ]

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

Have you ever had a sleep test?	Yes [ ] No [ ]	Have you ever had orthodontic (braces) treatment?	Yes [ ] No [ ]
Do you have sores or ulcers in your mouth?	Yes [ ] No [ ]	Do you wear dentures or partials?	Yes [ ] No [ ]
Is there anything you would like to change about your smile?	Yes [ ] No [ ]		

DENTAL HISTORY

Complete the following fields if you are NEW PATIENT or if you have regular appointments with another dental provider.

Date of your last dental exam
Date of your last dental x-rays?

PREVIOUS OR OTHER DENTAL PROVIDER INFORMATION

Dental Provider or Practice Name:

Dental Provider or Practice Phone#:

MEDICAL INFORMATION

Do you use tobacco (smoking, snuff, chew, vaping)?	Yes [ ] No [ ]	Do you consume alcohol or use recreational drugs?	Yes [ ] No [ ]
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes [ ] No [ ]	Have you been instructed by a physician or dentist to take antibiotics prior to dental treatment for a heart condition or joint replacement?	Yes [ ] No [ ]
Are you currently under the care of a physician?	Yes [ ] No [ ]		

***If you are currently under the care of a physician, please complete the "Physician Information" section.*

**PHYSICIAN INFORMATION

Physician Name:

Physician Phone Number:

Date of last visit:

Did you have bloodwork completed as part of your last visit? Yes [ ] No [ ]

HABITS

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Speech problems	Yes [ ] No [ ]	Mouth breather	Yes [ ] No [ ]
Thumb/finger sucking	Yes [ ] No [ ]	Tongue Thrust	Yes [ ] No [ ]
Lip sucking/biting	Yes [ ] No [ ]	Nail biting	Yes [ ] No [ ]

MEDICATION

Are Yes [ ] No [ ] Have Yes [ ] No [ ] Are Yes [ ] No [ ] Are Yes [ ] No [ ]

you prescribed blood thinners? (Aspirin, Heparin, Warfarin, etc.)	you taken medications containing bisphosphonates?	you currently taking any GLP-1 medications for weight loss?	you taking any prescription or over the counter medication(s)?

Please list all prescribed or over the counter medication(s).

Medication	Dosage	Frequency

ALLERGIES

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Anesthesia	Yes [ ]	No [ ]	Aspirin	Yes [ ]	No [ ]
Barbiturates, sedatives, or sleeping pills	Yes [ ]	No [ ]	Codeine or other narcotics	Yes [ ]	No [ ]
Sulfa drugs	Yes [ ]	No [ ]	Tetracycline/Erythromycin / Penicillin / Other antibiotics	Yes [ ]	No [ ]
Jewelry / Metals	Yes [ ]	No [ ]	Latex (rubber)	Yes [ ]	No [ ]
Hay fever/ Seasonal	Yes [ ]	No [ ]			
Do you have any allergies not listed above?				Yes [ ]	No [ ]

Please list any allergies not listed above:

Allergies

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

Allergies

JOINT REPLACEMENT/IMPLANT

Have you ever undergone a total orthopedic joint replacement or had any orthopedic implants placed in your body? Yes [ ] No [ ]

Date Of Replacement or Implant:

HEART CONDITIONS

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Arteriosclerosis / Coronary artery disease	Yes [ ]	No [ ]	Artificial (prosthetic) heart valve	Yes [ ]	No [ ]
Cardiac stent	Yes [ ]	No [ ]	Cardiovascular disease	Yes [ ]	No [ ]
Chest pain / Angina	Yes [ ]	No [ ]	Congestive Heart Failure	Yes [ ]	No [ ]
Congenital heart disease (CHD)	Yes [ ]	No [ ]	Heart Attack	Yes [ ]	No [ ]
Heart murmur	Yes [ ]	No [ ]	High blood pressure	Yes [ ]	No [ ]
History of Endocarditis	Yes [ ]	No [ ]	Low blood pressure	Yes [ ]	No [ ]
Mitral valve prolapse	Yes [ ]	No [ ]	Pacemaker	Yes [ ]	No [ ]

MEDICAL CONDITIONS, DISEASES, AND PROBLEMS

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Pregnant/Nursing?	Yes [ ]	No [ ]	Taking birth control pills or hormonal replacement?	Yes [ ]	No [ ]
Anemia	Yes [ ]	No [ ]	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	Yes [ ]	No [ ]
Hemophilia / Abnormal bleeding	Yes [ ]	No [ ]	Blood transfusion	Yes [ ]	No [ ]
Arthritis / Pain in joints	Yes [ ]	No [ ]	HIV + / AIDS	Yes [ ]	No [ ]
Asthma / Breathing problems	Yes [ ]	No [ ]	Tuberculosis	Yes [ ]	No [ ]
Emphysema / Bronchitis / Persistent cough	Yes [ ]	No [ ]	Sinus trouble	Yes [ ]	No [ ]
Rheumatic fever	Yes [ ]	No [ ]	Hearing or Vision Impairment	Yes [ ]	No [ ]
Cancer / Chemotherapy / Radiation	Yes [ ]	No [ ]	Chronic pain	Yes [ ]	No [ ]
Diabetes	Yes [ ]	No [ ]	Glaucoma	Yes [ ]	No [ ]
Hepatitis / Jaundice / Liver disease	Yes [ ]	No [ ]	Mental health disorders(ie Anxiety, Depression, Bipolar)	Yes [ ]	No [ ]
Neurological disorders	Yes [ ]	No [ ]	Snoring	Yes [ ]	No [ ]
Sleep disorder	Yes [ ]	No [ ]	Severe / Rapid weight loss	Yes [ ]	No [ ]
Eating disorder / Malnutrition	Yes [ ]	No [ ]	Gastrointestinal disease	Yes [ ]	No [ ]
Reflux / Persistent heartburn	Yes [ ]	No [ ]	Sores / Ulcers in the mouth	Yes [ ]	No [ ]

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

Thyroid problems	Yes [ ]	No [ ]	Stroke	Yes [ ]	No [ ]
Epilepsy / Seizures	Yes [ ]	No [ ]	Dizziness / Fainting	Yes [ ]	No [ ]
Recurrent Infections	Yes [ ]	No [ ]	Kidney problems	Yes [ ]	No [ ]
Night sweats	Yes [ ]	No [ ]	Osteoporosis	Yes [ ]	No [ ]
Persistent swollen glands in neck	Yes [ ]	No [ ]	Frequent / Severe headaches	Yes [ ]	No [ ]
Sexually transmitted disease	Yes [ ]	No [ ]	Difficulty urinating / Prostate	Yes [ ]	No [ ]
Do you have any other diseases, conditions, problem, or special needs or accommodations not listed above?				Yes [ ]	No [ ]

Please list any other diseases, conditions, problem, special needs or accommodations not listed above.

Problems

SIGNATURE

I consent to use Electronic Records and Signatures

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature:
Relationship To Patient:

Dental Information

Patient: Submitted: 11/7/2024

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.

PATIENT INFORMATION

Patient Name:

Date of Birth:

DENTAL INFORMATION

DENTAL HEALTH

PLEASE SELECT YES OR NO TO THE FOLLOWING DENTAL HEALTH QUESTIONS:

Do you have any immediate dental concerns?	Yes [ ] No [ ]	Are you currently experiencing dental pain or discomfort?	Yes [ ] No [ ]
Have you had any problems with previous dental treatment?	Yes [ ] No [ ]	Have you ever had a serious injury to your head or mouth?	Yes [ ] No [ ]
Do your gums bleed when you brush or floss?	Yes [ ] No [ ]		
Have you ever had teeth become loose, without injury?	Yes [ ] No [ ]	Have you had any periodontal (gum) treatments?	Yes [ ] No [ ]
Have you had any cavities in the last 3 years?	Yes [ ] No [ ]	Are your teeth sensitive to cold, hot, sweets or pressure?	Yes [ ] No [ ]
Do you ever have times your mouth feels dry?	Yes [ ] No [ ]	Do you brux, grind, or clinch your teeth?	Yes [ ] No [ ]
Do you have earaches or neck pains?	Yes [ ] No [ ]		
Do you have any clicking, popping or discomfort in the jaw?	Yes [ ] No [ ]	Have your teeth become shorter, thinner, or worn in the last 5 years?	Yes [ ] No [ ]
Have you ever had a sleep test?	Yes [ ] No [ ]		
Have you ever had orthodontic (braces) treatment?	Yes [ ] No [ ]	Do you have sores or ulcers in your mouth?	Yes [ ] No [ ]
Do you wear dentures or partials?	Yes [ ] No [ ]	Is there anything you would like to change about your smile?	Yes [ ] No [ ]

DENTAL HISTORY

Complete the following fields if you are NEW PATIENT or if you have regular appointments with another dental provider.

Dental Information

Patient: Submitted: 11/7/2024

Date of your last dental exam
Date of your last dental x-rays?

PREVIOUS OR OTHER DENTAL PROVIDER INFORMATION

Dental Provider or
Practice Name:

Dental Provider or
Practice Phone Number:

SIGNATURE

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Financial Policy, Appointment Policy, & Image Consent

Patient: Submitted: 4/24/2024

Patient Information

Patient Name
Relationship to patient

Self: [ ]	Parent: [ ]	Spouse: [ ]
Guardian: [ ]	Other: [ ]	

FINANCIAL POLICY

Thank you for choosing us as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement from our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:
Your dental provider accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The dental benefit contract is an agreement between you and the dental benefit company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, your dental team may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that your dental plan is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

PAYMENT:
Payment for services, including deductibles and copayments, are due at the time of the service unless other arrangements have been made prior to treatment. This includes but is not limited to dental fees, surgical procedures, tests, office procedures, medications, and any other services not directly provided by the dentist.

Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment. For more information on what third-party financing options your dental provider accepts, please contact your dental team.

Checks that are returned to our office from your financial institution may be subject to a returned check fee. This fee covers the processing fees that are charged to our office. Please indicate your understanding and acceptance of these financial policies by signing below.

*__Full payment__ *is due at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service, unless other arrangements are made.*

*__Unpaid balances over 90 days__ *(about 3 months) old may be subject to a monthly interest charge. If payment is delinquent, the patient will be responsible for payment of collection, attorneys' fees, and court costs associated with the recovery of the monies due in the account.*

By signing below you indicate your understanding and acceptance of the aforementioned financial policies.

APPOINTMENT POLICY

If you find that you must change your appointment, a minimum of 24 hours or 1 business day notice is required.

Your appointment represents a reservation for time with your dental team to provide your service and adequate notice of a needed schedule change offers us the ability to redirect our resources to other patients and their necessary treatment.

If proper notice is not received, a fee may be charged for each changed appointment.

By signing below you indicate your understanding and acceptance of the aforementioned Appointment policy.

CONSENT FOR THE USE OF PHOTO/X-RAYS

Clinical Imagery play a key role in the education of medical and dental staff at all levels, and thus benefit future patients.

I grant my dental team permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders.

I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance.

I do consent to the use of my photographs or images for marketing materials including website and patient education.

I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used. **No full face or comparable photos will be used without your express written authorization.**

I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications.

I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

***By signing below you indicate your understanding and acceptance of the aforementioned statements and you authorize and consent to the use of photographs/x-rays of me taken by my dental team.**

Patient Information

Patient Name

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE READ IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information (PHI), provide individuals with a notice of our legal duties and privacy practices regarding PHI, and notify affected individuals following a breach of unsecured PHI. We must follow the privacy practices described in this Notice as long as it is in effect. This Notice is effective as of May 5, 2020, and will remain in effect until it is replaced.

We reserve the right to change our privacy practices and the terms of this Notice at any time, as permitted by applicable law. New provisions will be effective for all PHI we maintain. When significant changes are made, we will update this Notice and post it prominently at our practice location, and provide copies of the updated Notice upon request.

You may request a copy of this Notice at any time. For more information about our privacy practices or to request additional copies of this Notice, please contact us.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information for various purposes, including treatment, payment, and healthcare operations. Below are the descriptions and examples of these categories. Some information, such as HIV-related information, genetic data, alcohol/substance abuse records, and mental health records, may be subject to special confidentiality protections under applicable law. We will adhere to these protections as required.

- **Treatment:** We may use and disclose your health information for your treatment. For example, we may share information with a specialist involved in your care.
- **Payment:** We may use and disclose your health information to obtain payment for the treatment and services you receive. This includes activities such as billing, collections, claims management, and determining eligibility for coverage. For example, we may submit claims to your insurance company that contain health information.
- **Healthcare Operations:** We may use and disclose your health information for healthcare operations, such as quality improvement activities, training programs, and licensing.
- **Individuals Involved in Your Care or Payment for Your Care:** We may disclose your health information

individuals you identify as being involved in your care or the payment for your care. This includes family members, friends, or patient representatives with legal authority to make healthcare decisions for you.

- **Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.
- **Required by Law:** We may use or disclose your health information when required by law.
- **Public Health Activities:** We may disclose your health information to public health authorities for activities such as:
- Preventing or controlling disease, injury, or disability.
- Reporting child abuse or neglect.
- Reporting medication reactions or issues with products.
- Notifying people of product recalls or exposure to disease.
- **National Security:** We may disclose your health information to military authorities, federal officials, or law enforcement under certain circumstances, including for national security or law enforcement activities.
- **Secretary of HHS:** We may disclose your health information to the Secretary of the U.S. Department of Health and Human Services to investigate or enforce compliance with HIPAA.
- **Workers Compensation:** We may disclose your health information as authorized to comply with workers' compensation laws or similar programs.
- **Law Enforcement:** We may disclose your health information for law enforcement purposes, as permitted or required by law.
- **Health Oversight Activities:** We may disclose your health information to oversight agencies conducting audits, investigations, or inspections related to licensure and compliance.
- **Judicial and Administrative Proceedings:** We may disclose your health information in response to a court or administrative order, subpoena, or discovery request, after efforts have been made to notify you or obtain a protective order.
- **Research:** We may disclose your health information to researchers with approval from an institutional review board or privacy board ensuring privacy protocols.
- **Coroners, Medical Examiners, and Funeral Directors:** We may release your health information to a coroner or medical examiner for purposes such as determining cause of death. We may also disclose information to funeral directors as necessary.
- **Fundraising:** We may contact you for fundraising purposes related to our practice, as permitted by law. You may opt-out of receiving such communications.
- **Other Uses and Disclosures:** In some cases, your authorization is required for disclosures of psychotherapy notes, marketing, or the sale of PHI. You will be asked for your written authorization before we use or disclose your PHI for any purpose not outlined in this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- **Access:** You have the right to inspect or obtain copies of your health information, with certain exceptions. Requests must be made in writing, and you may obtain a request form from us. Fees may apply for copying and postage.
- **Disclosure Accounting:** You have the right to request an accounting of certain disclosures of your health information. Requests must be submitted in writing. A reasonable, cost-based fee may apply for additional requests within a 12-month period.
- **Request Restrictions:** You may request restrictions on how we use or disclose your health information by submitting a written request. We are not required to agree to your request except in cases involving full payment for healthcare items or services.
- **Alternative Communication:** You have the right to request that we communicate with you about your

health information by alternative means or at alternative locations. We will accommodate reasonable requests.

- **Amendment:** You have the right to request an amendment to your health information if you believe it is incorrect or incomplete. Requests must be in writing and explain the reason for the amendment. We may deny your request in certain circumstances.
- **Notification of Breach:** You will be notified if there is a breach of your unsecured protected health information as required by law.
- **Electronic Notice:** You may request a paper copy of this Notice even if you have agreed to receive it electronically.

QUESTIONS AND COMPLAINTS

If you have questions or concerns about our privacy practices, or if you believe we may have violated your privacy rights, please contact us.

You also have the right to file a complaint with the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. We will provide the address to file a complaint upon request.

We support your right to privacy, and will not retaliate in any way for filing a complaint.

HIPAA Authorization to Release Information

HIPPA laws do not authorized the release protected health information (PHI) without the written consent. To authorize the practice to release PHI please list the contact information for the person(s) in the space provided below.

Full Name	Phone Number
Full Name:	Phone Number:
Full Name:	Phone Number:
Full Name:	Phone Number:

Sign Form

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

(Read Electronic Record and Signature Disclosure)

Relationship to patient

Self: [ ]	Parent: [ ]	Spouse: [ ]
Guardian: [ ]	Other: [ ]	

HIPAA Notice Of Privacy And Consent

Patient: Submitted: 4/23/2024

I consent to use Electronic Records and Signatures: [ ]

Insurance Information

Patient: Submitted: 4/24/2024

Patient Information

First Name Last Name

Does the patient currently have ACTIVE dental insurance coverage? Yes [ ] No [ ]

(Returning Patients) Have there been any changes to your dental insurance since your last appointment? Yes [ ] No [ ]

**New patients *with active dental insurance and* returning patients with changes *to dental insurance please complete the* Primary Dental Insurance *sections and* Secondary Insurance *sections (if applicable)*

Primary Dental Insurance

Insurance Company Information

Insurance Company Name
Insurance Company Phone Number
Type of Plan
Group #
Subscriber ID#

***If the Subscriber ID# is unknown, please provide the plan subscriber's Social Security number.**

Insured (Subscriber Information)

Employer Information

Is the plan through an employer? Yes [ ] No [ ]

Employer/Company Name

Secondary Dental Insurance

Do you have secondary insurance you'd like to use? Yes [ ] No [ ]

Insurance Company Information

Insurance Company Name
Insurance Company Phone Number
Type of Plan
Group #
Subscriber ID#

***If the Subscriber ID# is unknown, please provide the plan subscriber's Social Security number.**

Insured (Subscriber Information)

Insurance Information

Patient: Submitted: 4/24/2024

Employer Information

Is the plan through an employer? Yes [ ] No [ ]
Employer/Company Name

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. (Read Electronic Record and Signature Disclosure)

I consent to use Electronic Records and Signatures: [ ]

Medical Information

Patient: Submitted: 11/7/2024

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.

PATIENT INFORMATION

First Name:
Last Name:
Date of Birth:

MEDICAL INFORMATION

Do you use tobacco (smoking, snuff, chew, vaping)?	Yes [ ] No [ ]
Do you consume alcohol or use recreational drugs?	Yes [ ] No [ ]
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes [ ] No [ ]
Have you been instructed by a physician or dentist to take antibiotics prior to dental treatment for a heart condition or joint replacement?	Yes [ ] No [ ]
Are you currently under the care of a physician?	Yes [ ] No [ ]

***If you are currently under the care of a physician, please complete the "Physician Information" section.*

**PHYSICIAN INFORMATION

Physician Name: Physician Phone Number:
Date of last visit:
Did you have bloodwork completed as part of your last visit? Yes [ ] No [ ]

HABITS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Thumb/finger sucking	Yes [ ] No [ ]	Tongue Thrust	Yes [ ] No [ ]
Lip sucking/biting	Yes [ ] No [ ]	Speech problems	Yes [ ] No [ ]
Mouth breather	Yes [ ] No [ ]	Nail biting	Yes [ ] No [ ]

MEDICATION

Are you prescribed blood thinners? (Aspirin, Heparin, Warfarin, etc.)	Yes [ ] No [ ]
Have you ever taken any medications containing bisphosphonates (i.e. Fosamax and Boniva)?	Yes [ ] No [ ]
Are you currently taking any GLP-1 medications for weight loss?	Yes [ ] No [ ]
Are you taking any prescription or over the counter medication(s)?	Yes [ ] No [ ]

Please list all prescribed or over the counter medication(s).

Medical Information

Patient: Submitted: 11/7/2024

Medication	Dosage	Frequency

ALLERGIES

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Anesthesia	Yes [ ] No [ ]	Aspirin	Yes [ ] No [ ]
Barbiturates/sedatives/ sleeping pills	Yes [ ] No [ ]	Codeine or other narcotics	Yes [ ] No [ ]
Sulfa drugs	Yes [ ] No [ ]	Tetracycline/ Erythromycin/Penicillin/ Other antibiotics	Yes [ ] No [ ]
Jewelry/Metals	Yes [ ] No [ ]	Latex (rubber)	Yes [ ] No [ ]
Hay fever/ Seasonal		Yes [ ] No [ ]	
Do you have any allergies not listed above?		Yes [ ] No [ ]	

Please list any allergies not listed above:

Allergies

JOINT REPLACEMENT/IMPLANT

Yes [ ] No [ ]

Do you have any artificial orthopedic joints or had any orthopedic implants placed in your body?

Date Of Replacement or Implant:

HEART CONDITIONS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Artificial (prosthetic) heart valve	Yes [ ] No [ ]	Congenital heart disease (CHD)	Yes [ ] No [ ]
Cardiovascular disease	Yes [ ] No [ ]	Chest pain / Angina	Yes [ ] No [ ]
Arteriosclerosis / Coronary artery disease	Yes [ ] No [ ]	Congestive heart failure	Yes [ ] No [ ]
Heart attack	Yes [ ] No [ ]	Heart murmur	Yes [ ] No [ ]
Low blood pressure	Yes [ ] No [ ]	High blood pressure	Yes [ ] No [ ]
Mitral valve prolapse	Yes [ ] No [ ]	Pacemaker	Yes [ ] No [ ]
Cardiac stent	Yes [ ] No [ ]	History of Endocarditis	Yes [ ] No [ ]

MEDICAL CONDITIONS, DISEASES, AND PROBLEMS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Pregnant/Nursing?	Yes [ ] No [ ]	Taking birth control pills or hormonal replacement?	Yes [ ] No [ ]
Hemophilia / Abnormal bleeding	Yes [ ] No [ ]	Blood transfusion	Yes [ ] No [ ]
Anemia	Yes [ ] No [ ]	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	Yes [ ] No [ ]
HIV + / AIDS	Yes [ ] No [ ]	Arthritis / Pain in joints	Yes [ ] No [ ]
Asthma / Breathing problems	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
Emphysema / Bronchitis / Persistent cough	Yes [ ] No [ ]	Sinus trouble	Yes [ ] No [ ]
Rheumatic fever	Yes [ ] No [ ]	Hearing or Vision Impairment	Yes [ ] No [ ]
Cancer / Chemotherapy / Radiation	Yes [ ] No [ ]	Chronic pain	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Glaucoma	Yes [ ] No [ ]
Hepatitis / Jaundice / Liver disease	Yes [ ] No [ ]	Mental Health Conditions (e.g., anxiety, depression, bipolar)	Yes [ ] No [ ]
Neurological disorders	Yes [ ] No [ ]	Snoring	Yes [ ] No [ ]
Sleep disorder	Yes [ ] No [ ]	Severe / Rapid weight loss	Yes [ ] No [ ]
Eating disorder / Malnutrition	Yes [ ] No [ ]	Gastrointestinal disease	Yes [ ] No [ ]
Reflux / Persistent heartburn	Yes [ ] No [ ]	Sores / Ulcers in the mouth	Yes [ ] No [ ]
Thyroid problems	Yes [ ] No [ ]	Stroke	Yes [ ] No [ ]
Epilepsy / Seizures	Yes [ ] No [ ]	Dizziness / Fainting	Yes [ ] No [ ]
Recurrent Infections	Yes [ ] No [ ]	Kidney problems	Yes [ ] No [ ]
Night sweats	Yes [ ] No [ ]	Osteoporosis	Yes [ ] No [ ]
Persistent swollen glands in neck	Yes [ ] No [ ]	Frequent / Severe headaches	Yes [ ] No [ ]
Sexually transmitted	Yes [ ] No [ ]	Difficulty urinating /	Yes [ ] No [ ]

infection
Do you have any other diseases, conditions, problem, or special needs or accommodations not listed above?

Prostate
Yes [ ] No [ ]

Please list any other diseases, conditions, problem, special needs or accommodations not listed above.

Problems

SIGNATURE

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient Information

Patient: Submitted: 11/7/2024

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.

PATIENT INFORMATION

Patient Name:
Date of Birth:
Gender:
Social Security Number:
Primary Phone Number:
Email Address:
Address:
Address Line 2 (Optional):
City:
State:
Zip:

EMERGENCY CONTACT INFORMATION

1. Full Name:
Phone Number:
2. Full Name:
Phone Number:

REFERRAL SOURCE:

How did you hear about our office?
If applicable, provide the name of who we can thank:

PHARMACY INFORMATION

Do you have a preferred pharmacy that you would like us to keep on file?
Yes [ ] No [ ]
Pharmacy Name

SIGNATURE

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.