Medical History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone Number) _____

Medical History

Email Address _____

1. Physician _____ Address _____

2. When was your last physical examination? _____

3. Are you under the care of a physician? ☐ Yes ☐ No

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals? ☐ Yes ☐ No

If yes, please list: _____

5. (Women) Is there a chance you are pregnant? ☐ Yes ☐ No

If yes, How long? _____

6. Do you take oral contraceptives? ☐ Yes ☐ No

7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Pine Nuts ☐Dyes ☐ Other _____

8. Do you smoke or chew tobacco? ☐ Yes ☐ No

If yes, which one or both and how long? _____

9. Do you have Diabetes? ☐ Yes ☐ No

If Yes, please indicate ☐ Type 1 ☐ Type 2 Last HbA1c date and level _____

10. Do you have, or have you ever had:

Heart trouble	☐Yes☐No	Excessive or prolonged bleeding	☐Yes☐No
Heart murmur	☐Yes☐No	Thyroid problem	☐Yes☐No
Heart surgery	☐Yes☐No	Jaundice	☐Yes☐No
Heart pacemaker	☐Yes☐No	Hepatitis(Type)	☐Yes☐No
Rheumatic fever	☐Yes☐No	Cancer	☐Yes☐No
Congenital heart defects	☐Yes☐No	Chemotherapy/radiation	☐Yes☐No
Artificial heart valve/stent/graft	☐Yes☐No	Arthritis	☐Yes☐No
Abnormal blood pressure	☐Yes☐No	Artificial joint replacements	☐Yes☐No
Stroke	☐Yes☐No	Cortico-Steroid treatment	☐Yes☐No
Ulcers/ GERD	☐Yes☐No	Osteoporosis/treatment w/ Bisphosphonates	☐Yes☐No
Kidney trouble/Dialysis	☐Yes☐No	HIV positive/AIDS	☐Yes☐No
Tuberculosis or lung disease	☐Yes☐No	Oral herpetic lesions	☐Yes☐No
Asthma	☐Yes☐No	Sexually Transmitted disease	☐Yes☐No
Sinus trouble	☐Yes☐No	Psychiatric care	☐Yes☐No
Epilepsy/seizures	☐Yes☐No	Glaucoma	☐Yes☐No
Fainting spells	☐Yes☐No	Hearing impaired	☐Yes☐No
Anemia	☐Yes☐No	Chemical dependency	☐Yes☐No
Leukemia	☐Yes☐No	Do you take pre-medication for anything	☐Yes☐No
		If you pre-medicate for what	_____

11. Have you had any other serious illness, hospitalization or accident? ☐Yes ☐No

If yes, please explain: _____

(OVER PLEASE)

HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

Dental History

1. Former Dentist_____ Address _____
2. When did you last visit a dentist?_____ When was your last cleaning? _____

X-rays taken? ..... ☐ Yes ☐ No

If yes: ☐ Full Mouth Series ☐ Bitewings ☐ Panoramic -

What was done at your last visit? _____

Why did you leave that dentist? _____

Has any dental treatment been recommended to you that you have not had done? _____

3. Are you aware of any dental problems? ..... ☐ Yes ☐ No

Explain: _____

4. Please rate the present condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
5. Have you ever been treated for gum disease? ..... ☐ Yes ☐ No

If yes, what was done?_____

6. Do you have well water? ..... ☐ Yes ☐ No
7. Is your water fluoridated? ..... ☐ Yes ☐ No
8. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure
9. Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
10. Would you like a whiter smile? ..... ☐ Yes ☐ No
11. Would you like straighter teeth? ..... ☐ Yes ☐ No
12. Have you had your teeth straightened/worn braces? ..... ☐ Yes ☐ No
13. Are you concerned with bad breath (malodor)? ..... ☐ Yes ☐ No
14. Are you concerned with snoring or sleep apnea? ..... ☐ Yes ☐ No
15. Are you concerned with grinding or clenching your teeth (bruxism)?..... ☐ Yes ☐ No
16. Do you wear a bite guard? ..... ☐ Yes ☐ No
17. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain?.. ☐ Yes ☐ No
18. Are you interested in sleep/ sedation dentistry? ..... ☐ Yes ☐ No
19. Is there anything else that would be valuable for your dentist to know to best care for you? _____

_____

- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**
- **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.**
- **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.**

Patient Signature_____ Date _____

(Parent/Guardian)

Recorded by_____ Dentist Signature_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FORM

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2013.

We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Authorization of PHI Disclosure

The information described above may be disclosed to the following recipients:

- Name of Person #1: _____ Relationship to You: _____
- Name of Person #2: _____ Relationship to You: _____

I understand that MDSC will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, MDSC will not provide the treatment if I am unwilling to sign this authorization form.

- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, MDSC will not provide the treatment if I am unwilling to sign this authorization form.

Revocation of PHI Disclosure

I understand that I may revoke this authorization by completing a new *Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form*. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that MDSC may have already made in reliance on this authorization. If I revoke this authorization, MDSC will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when MDSC discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

By signing below, I am acknowledging that I have received a copy of MDSC's Notice of Privacy Practices. I am also giving MDSC consent to disclose my protected health information to the person(s) listed above until such time a new *Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form* is completed by me. I also understand and agree to the terms of this authorization.

Patient Name: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Signature: _____ Date: _____, 20____

To be completed by MDSC personnel if form is not signed:

I, _____, attempted to obtain the patient's acknowledgement of receipt of Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement and consent not obtained: _____

Employee Signature: _____ Date: _____, 20_____