Fishhawk Family Dental

# Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| Question | Answer | |
|---|---|---|
| Are you under a physician's care/ being treated for any illness or condition at this time? | ◯ Yes ◯ No | If yes |
| Have you ever been hospitalized or had a major operation? | ◯ Yes ◯ No | If yes |
| Have you ever had a serious head or neck injury? | ◯ Yes ◯ No | If yes |
| Are you taking any medications, pills, or drugs? | ◯ Yes ◯ No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | ◯ Yes ◯ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ◯ Yes ◯ No | If yes |
| Do you use tobacco or controlled substances? | ◯ Yes ◯ No | |
| Do you routinely premedicate prior to dental treatment? | ◯ Yes ◯ No | If yes |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Acrylic |
| ☐ Metal | ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics |

Other? ☐ If yes

Do you have, or have you had, any of the following?

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ◯ Yes ◯ No | Diabetes | ◯ Yes ◯ No | Hemophilia | ◯ Yes ◯ No | Radiation Treatments | ◯ Yes ◯ No |
| Alzheimer's Disease | ◯ Yes ◯ No | Drug/Alcohol Addiction | ◯ Yes ◯ No | Hepatitis A | ◯ Yes ◯ No | Recent Weight Loss | ◯ Yes ◯ No |
| Anaphylaxis | ◯ Yes ◯ No | Easily Winded | ◯ Yes ◯ No | Hepatitis B or C | ◯ Yes ◯ No | Renal Dialysis | ◯ Yes ◯ No |
| Anemia | ◯ Yes ◯ No | Eating Disorder | ◯ Yes ◯ No | Herpes | ◯ Yes ◯ No | Rheumatic Fever | ◯ Yes ◯ No |
| Angina | ◯ Yes ◯ No | Emphysema | ◯ Yes ◯ No | High Blood Pressure | ◯ Yes ◯ No | Rheumatism | ◯ Yes ◯ No |
| Arthritis/Gout | ◯ Yes ◯ No | Epilepsy or Seizures | ◯ Yes ◯ No | High Cholesterol | ◯ Yes ◯ No | Scarlet Fever | ◯ Yes ◯ No |
| Artificial Heart Valve | ◯ Yes ◯ No | Excessive Bleeding | ◯ Yes ◯ No | Hives or Rash | ◯ Yes ◯ No | Shingles | ◯ Yes ◯ No |
| Artificial Joint | ◯ Yes ◯ No | Excessive Thirst | ◯ Yes ◯ No | Hypoglycemia | ◯ Yes ◯ No | Sickle Cell Disease | ◯ Yes ◯ No |
| Asthma | ◯ Yes ◯ No | Fainting Spells/Dizziness | ◯ Yes ◯ No | Irregular Heartbeat | ◯ Yes ◯ No | Sinus Trouble | ◯ Yes ◯ No |
| Blood Disease | ◯ Yes ◯ No | Frequent Cough | ◯ Yes ◯ No | Kidney Problems | ◯ Yes ◯ No | Spina Bifida | ◯ Yes ◯ No |
| Blood Transfusion | ◯ Yes ◯ No | Frequent Diarrhea | ◯ Yes ◯ No | Leukemia | ◯ Yes ◯ No | Stomach/Intestinal Disease | ◯ Yes ◯ No |
| Breathing Problems | ◯ Yes ◯ No | Frequent Headaches | ◯ Yes ◯ No | Liver Disease | ◯ Yes ◯ No | Stroke | ◯ Yes ◯ No |
| Bruise Easily | ◯ Yes ◯ No | Low Blood Pressure | ◯ Yes ◯ No | Swelling of Limbs | ◯ Yes ◯ No | Cancer | ◯ Yes ◯ No |
| Glaucoma | ◯ Yes ◯ No | Lung Disease | ◯ Yes ◯ No | Thyroid Disease | ◯ Yes ◯ No | Chemotherapy | ◯ Yes ◯ No |
| Hay Fever | ◯ Yes ◯ No | Mitral Valve Prolapse | ◯ Yes ◯ No | Tonsillitis | ◯ Yes ◯ No | Chest Pains | ◯ Yes ◯ No |
| Heart Attack/Failure | ◯ Yes ◯ No | Osteoporosis | ◯ Yes ◯ No | Tuberculosis | ◯ Yes ◯ No | Cold Sores/Fever Blisters | ◯ Yes ◯ No |
| Heart Murmur | ◯ Yes ◯ No | Pain in Jaw Joints | ◯ Yes ◯ No | Tumors or Growths | ◯ Yes ◯ No | Congenital Heart Disorder | ◯ Yes ◯ No |
| Heart Pacemaker | ◯ Yes ◯ No | Parathyroid Disease | ◯ Yes ◯ No | Ulcers | ◯ Yes ◯ No | Cortisone Medicine | ◯ Yes ◯ No |
| Heart Trouble/Disease | ◯ Yes ◯ No | Psychiatric Care | ◯ Yes ◯ No | Venereal Disease | ◯ Yes ◯ No | Yellow Jaundice | ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X Date:__________

# PEDIATRIC DENTAL HISTORY

Patient Name: ______________________________ Date of last dental exam: ______________

Date of last full mouth x-rays: ______________________ Where taken: ____________________

| Please review the following and check either "YES" or "NO" | YES | NO |
|---|---|---|
| Any previous unhappy medical or dental visits? | | |
| Has your child complained about any dental problems? | | |
| Any injuries to mouth, teeth, or head? | | |
| Any mouth habit such as thumb sucking, nail biting, mouth breathing, etc? | | |
| Any lost teeth? | | |
| Do you assist your child with brushing? (If yes, how often? ____________________) | | |
| Is dental floss used? | | |
| Are disclosing tablets used? | | |

How does your child receive fluoride? (Please circle all that apply)

Water supply Dentist Vitamin Toothpaste Tablets None

What is your child's attitude towards dentistry? ________________________________

Is there any problem or concern other than the above that you would like to discuss?

________________________________________________________________

________________________________________________________________

# PATIENT REGISTRATION

**Patient Name:** ______________________________ **Date of Birth:** ____________________

## PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Date of Birth: __________________ Social Security #: ______________________

Address: ______________________________________________________

City: ______________________ State: ________ Zip Code: ______________

Home Phone #: ____________________ Cell Phone #: ____________________

E-mail Address: __________________________________________________

Driver’s License #: ________________________________________________

## RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First Name: ______________________ Last Name: ______________________

Date of Birth: __________________ Social Security #: ______________________

Address: ______________________________________________________

City: ______________________ State: ________ Zip Code: ______________

Home Phone #: ____________________ Cell Phone #: ____________________

E-mail Address: __________________________________________________

Driver’s License #: ________________________________________________

## INSURANCE INFORMATION

Ins Co Name: ____________________ Ins Co Phone #: ____________________

Name of Policy Holder: ____________________ Date of Birth: ______________

Subscriber ID #: _____________________________________________

Group Name: ________________________ Group #: __________________

***I do not have dental insurance or do not have applicable coverage in this office:***

**_____ I will pay with cash or credit card**

# PATIENT CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:**

- Treatment *(including direct or indirect treatment by other healthcare providers involved in my treatment)*
- Obtaining payment from my third party payers *(e.g. my insurance company)*
- The day to day healthcare operations of the practice

I have also been given the right to review and secure a copy of your Notice of Privacy Practices, **(*Notice of Privacy Practices is posted in our office, a copy will be provided upon request*)** which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name:________________________________ Date: ________________

Signature: _________________________ Relationship (if other than Patient): ________________

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# INSURANCE AUTHORIZATION

**I hereby authorize my healthcare provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company relating to any and all health benefits due to myself and my dependants.**

**I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor. I agree to be held responsible for all charges not paid by my insurance company**. *There is an insufficient fund fee of $25.00 for any returned check.*

**If this account becomes more than 90 days past due, I agree to pay all costs of collection fees and court costs.**

Signature: ________________________________ Date ________________

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# RELEASE OF PATIENT INFORMATION

I, (Patient Name) ___________________________________ give FishHawk Family Dental / Summerfield Family Dental permission to release or discuss any and all information concerning my treatment or charges to the following persons listed below:

❑ **YES, release to the following persons listed below:**

Name: __________________________________________ Relationship to Patient ________________

Name: __________________________________________ Relationship to Patient ________________

Name: __________________________________________ Relationship to Patient ________________

**- OR -**

❑ **NO, release to no one**

Patient Name: _______________________________________________ Date: ________________

Patient (or Legal Guardian) Signature: _________________________________________________

# OFFICE POLICIES

## APPOINTMENT POLICY

When an appointment is made in our office, a specific time is reserved for the patient to see the dentist or hygienist. A room is prepared and special instruments are readied to treat each patient's unique needs; insurance companies must be contacted to request plan specific eligibility and coverage information. Broken appointments result in a loss of valuable time that could have been spent with patients who are in need of treatment, and they are very costly to our office.

**For this reason, if a patient fails to keep an office visit he or she will be charged a $40 fee for a broken appointment.**

It is the patient's ultimate responsibility to keep their scheduled appointment. **If an appointment does need to be changed for any reason, please notify our office at least 24 hours in advance of the appointed time, and no broken appointment fee will be charged.**

In order to ensure each patient is given the time and attention they deserve, we adhere to a strict **10 minute rule**. **Patients who are more than 10 minutes late for their appointment will be asked to reschedule.**

## PARENTS OF MINOR PATIENTS

**Patients under the age of 18 years old must be accompanied by a parent or legal guardian.** Minor patients, who are unaccompanied to their appointment by a parent or legal guardian, **must have a note for permission to treat**. It must be signed by a parent or legal guardian and be provided to the office *prior to the scheduled appointment time*. **Minors without a parent or legal guardian present or a note for permission will not be treated.**

**Parents are not permitted in the treatment area once treatment has begun.** Parents may walk their child to the treatment area if they wish to do so.

Signature :________________________________________ Date: ____________

Relationship if other than Patient: ________________________________________

*Thank you for your understanding and cooperation, and for placing your trust in us to take care of you and your family.*