

## HEALTH HISTORY FORM

So that we may ensure we are looking after your needs, please review and complete the following questionnaire.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Title (Please circle): MR. MRS. MISS. MS. DR. SSN: \_\_\_\_\_

Family Status (Please circle): SINGLE MARRIED CHILD OTHER

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home/Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred By (Please circle): Website/Internet TV Specialist Insurance Company Other

Other Namay Location: Namay Team Member \_\_\_\_\_ Patient Referral - Name \_\_\_\_\_

Purpose of Visit: \_\_\_\_\_

### Have you had any of the following? (Please check each box that applies)

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Problems/Prosthetic Valve  | <input type="checkbox"/> Allergy to Anesthetics                  |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Allergy to Penicillin                   |
| <input type="checkbox"/> Low Blood Pressure               | <input type="checkbox"/> Allergy to Medications                  |
| <input type="checkbox"/> Artificial Joints                | <input type="checkbox"/> Allergy to Latex                        |
| <input type="checkbox"/> Rheumatic Fever                  | <input type="checkbox"/> Anemia/Other Blood Disorder             |
| <input type="checkbox"/> Circulatory Problems             | <input type="checkbox"/> Diabetes                                |
| <input type="checkbox"/> Organ Transplant                 | <input type="checkbox"/> Asthma                                  |
| <input type="checkbox"/> Previous Infective Endocarditis  | <input type="checkbox"/> Hepatitis (A, B, C, D or E)             |
| <input type="checkbox"/> HIV/AIDS                         | <input type="checkbox"/> Epilepsy                                |
| <input type="checkbox"/> Pacemaker                        | <input type="checkbox"/> Liver/Kidney Problems                   |
| <input type="checkbox"/> G.E. Reflux/Persistent Heartburn | <input type="checkbox"/> Cancer/Chemotherapy/Radiation Treatment |
| <input type="checkbox"/> Sleep Disorder                   | <input type="checkbox"/> Anxiety/Mood Disorder                   |
| <input type="checkbox"/> Excessive Bruising/Bleeding      | <input type="checkbox"/> Pregnancy - Current Due Date: _____     |
| <input type="checkbox"/> Ulcers (stomach)                 | <input type="checkbox"/> Other _____                             |
| <input type="checkbox"/> Sinus Trouble                    |  |
| <input type="checkbox"/> Tumor History                    |  |

Are you currently taking any drugs or medications? (If yes, please list below)

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**Do any of the following apply to you? (Please check each box that applies)**

- Does your jaw "click" or hurt?
- Do you grind your teeth?
- Have you ever had orthodontic treatment?
- Do you wear a dental night guard?
- Have you ever had periodontal (gum) treatment?
- Do you bite your lips or cheeks often?
- Do you smoke?
- Do you think you have occasional bad breath?
- Do your gums ever bleed when you brush your teeth?
- Do you experience sensitivity with hot/cold?
- Do your teeth ever hurt when you bite hard?
- Does floss tear between your teeth?
- Does food get jammed between your teeth?
- Is there anything else you would like us to know?

How long has it been since your last dental visit? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

Are you currently taking a medication for Osteoporosis? (Fosamax or Actonel) \_\_\_\_\_

**Name of your Primary Care Physician:**

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact (please provide name/relationship/phone number): \_\_\_\_\_

\_\_\_\_\_

**Primary Dental Insurance**

Name of Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Relationship to Subscriber (please circle one): SELF SPOUSE CHILD OTHER: \_\_\_\_\_

Subscriber ID: Group Number/ID: \_\_\_\_\_

Phone Number (should be listed on back of card): \_\_\_\_\_

**Secondary Dental Insurance**

Name of Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Relationship to Subscriber (please circle one): SELF SPOUSE CHILD OTHER: \_\_\_\_\_

Subscriber ID: Group Number/ID: \_\_\_\_\_

Phone Number (should be listed on back of card): \_\_\_\_\_

## Consent for Treatment

- 1) I hereby authorize the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
- 2) Upon such diagnosis, I authorize the dentist to perform all treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.
- 3) I agree to the use of anesthetics, sedatives, and all other medication as necessary. I fully understand that using an anesthetic agent embodies certain risk. I understand I can ask for a complete recital of any possible complications.
- 4) I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.
- 5) I authorize that this date may be reviewed by team members of the dental practice.

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 disclose my health information to carry out: Treatment, Obtain payment (i.e. my insurance co), The day-to-day healthcare operations.

I have been informed and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures under HIPAA and the right to change the terms of this notice from time to time and I may contact you any time to obtain a copy.

**\*\*To ensure timely treatment to all patients we require a 48 hour (2 business days) notice of intent to cancel in advance.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Responsible Party Signature (if under 18 years of age): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_