Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

Question	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ______________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? List medications, dosages and reason for taking ______________	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐
11. Are you hard of hearing?	☐	☐
12. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________	☐	☐
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
14. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐
15. Have you ever been pre-medicated or been advised to do so before dental treatment?	☐	☐

10. Do you have or have you had any of the following?

Condition	Yes	No	Condition	Yes	No
Heart Condition	☐	☐	Liver Disease	☐	☐
Heart Attack	☐	☐	Hepatitis	☐	☐
Stroke	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Thyroid Problems	☐	☐
Low Blood Pressure	☐	☐	Kidney Disease	☐	☐
Heart Murmur	☐	☐	HIV/AIDS	☐	☐
Cardiac Pacemaker	☐	☐	Sexually Transmitted Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Anemia/Blood Disorder	☐	☐
Infective Endocarditis	☐	☐	Cancer	☐	☐
Rheumatic Fever	☐	☐	Radiation Therapy	☐	☐
Angina	☐	☐	Chemotherapy	☐	☐
Epilepsy/Seizures	☐	☐	Glaucoma	☐	☐
Fainting	☐	☐	Arthritis	☐	☐
Anxiety/Emotional Disorders	☐	☐	Joint Replacement	☐	☐
Asthma	☐	☐	Autism/Behavior Disorder	☐	☐
Seasonal Allergies/Hay Fever	☐	☐	Developmental Delay	☐	☐
Emphysema	☐	☐	Any Special Needs	☐	☐
Tuberculosis	☐	☐	Any Disease, Condition, or Problem not listed above		
Other Respiratory Problems	☐	☐	______________		
Stomach Trouble/Ulcers	☐	☐	______________		

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam ______________

Question	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ______________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Health Care Provider Comments ______________

______________ Signature ______________ Date ______________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Preston Family Dental
604 E. Elm
Republic, MO 65738

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions. but if you do agree then you are bound to abide by such restrictions,

Patient Name: ______________ Relationship to Patient: ______________

Signature: ______________ Date: ______________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ______________ Initials: ______________ Reason: ______________