NAMAY DENTISTRY

HEALTH HISTORY FORM

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

Name:_____ Date of Birth:_____

Title (PLEASE CIRCLE ONE): **MR. MRS. MISS. MS. DR.** SSN:_____

Family Status (PLEASE CIRCLE ONE): **SINGLE MARRIED CHILD OTHER**

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Mobile Phone:_____Work Phone:_____

Email Address:_____

Occupation:_____

Referred By:_____

Purpose of Visit:_____

Have you had any of the following? Please check each box that applies:

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

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

_____

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?

Other Notes:_____

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

Name of your Physician:_____

Address:_____

Phone:_____

Emergency Contact (please provide name and phone):_____

Are you pregnant? If yes, when is your due date?_____

How long has it been since your last dental visit?_____

How often do you have dental examinations?_____

NAMAY DENTISTRY

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 the back of card): _____

NAMAY DENTISTRY

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.

Patient's Signature:_____ Date:_____

Parent/Responsible Party Signature:_____

Relationship to Patient:_____