ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?	☐	☐	☐
If yes, what medication are you taking? _____			
Are you taking any medication to treat **osteoporosis** or Paget's disease? Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).	☐	☐	☐
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).	☐	☐	☐
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking **hormonal replacements**?	☐	☐	☐
Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?	☐	☐	☐
Do you use **vaping products**?	☐	☐	☐
How many **alcoholic beverages** do you have per week? _____			
Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons?	☐	☐	☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally			
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____			
Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?**	☐	☐	☐
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking **birth control pills**?	☐	☐	☐
Pregnant? If yes, number of weeks: _____	☐	☐	☐
Nursing? If yes, number of weeks: _____	☐	☐	☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5°F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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Dental Associates of Rockville, LLC
50 Hale Street
Rockville, CT 06066

OFFICE AND FINANCIAL POLICY:

Payment for services is due at the time services are rendered. We accept cash, checks, credit cards, and CareCredit. Returned checks and account balances older than 90 days may be subject to additional fees.

Charges may also be made for broken appointments. We must have 48 hours (2 days) notice of cancellation of appointments. If we do not have the required 48-hour cancellation notice, you may be charged a "No Show" fee of $50-150 (depending on service type). Patients that miss two or more appointments without calling to cancel/change their appointment will be discharged/dismissed from our practice. We currently have a waiting list of patients for appointments. If you cannot make your appointment, please notify us so we can give someone else that appointment time. Frequent missed appointments have a huge impact on our ability to see and treat our patients and cannot be overlooked.

As a courtesy, our office may contact you via phone, text message, or email regarding appointments, treatment, and financial matters. By signing this policy and providing your contact information, you consent to these forms of communication.
We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts.
We must emphasize that as dental care providers, our relationship is with you, not your insurance company.
While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____
Patient's signature Date

AUTHORIZATION TO PAY BENEFITS AND TO RELEASE INFORMATION

I hereby authorize payment directly to the above name dentist of the dental benefits otherwise payable to me. I hereby authorize the above-named dentist to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

_____ _____
Patient's signature Date

Dental Associates of Rockville, L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone #: _____ Social Security# _____

Consent for Use and Disclosure of Health Information

Authorization: I authorize Dental Associates of Rockville, L.L.C. to use or disclose the following: (check one)

☐ - All of my health information.

☐ - My health information ONLY related to: _____

☐ - My health information from (dates) _____ to _____

☐ - Not Applicable

Disclosure: Dental Associates of Rockville, L.L.C. can disclose my health records per the above selected conditions to:

Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Email: _____

Please read the following statements carefully

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You consent to our disclosure of your protected health information all or in part to the party listed above. You also authorize insurance payment directly to this office.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy is available for you and we encourage you to read it carefully.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our contact person. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations; and to the party I listed in the disclosure section of this document.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ **Date:** _____

Relationship to Patient: _____