

## Patient Information & Health History



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:     Married     Divorced     Single

Emergency Contact Name & Relationship: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

### **DENTAL HISTORY:**

Reason for today's visit: \_\_\_\_\_

Previous Dentist's Name: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

Do you experience any of the following?

- |   |   |                                    |
|---|---|------------------------------------|
| <input type="checkbox"/> Tooth Pain           | <input type="checkbox"/> Sensitivity      | <input type="checkbox"/> Jaw Pain  |
| <input type="checkbox"/> Clenching / Grinding | <input type="checkbox"/> Misaligned teeth | <input type="checkbox"/> Staining  |
| <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Bleeding gums    | <input type="checkbox"/> Dry Mouth |

Have you ever had:

- |   |  |
|---|--|
| <input type="checkbox"/> Orthodontic Treatment (Braces or Invisalign) | <input type="checkbox"/> Oral Surgery                        |
| <input type="checkbox"/> Gum Disease Treatment                        | <input type="checkbox"/> Complications with Dental Treatment |

If yes, please explain: \_\_\_\_\_

Did anyone refer you to our office? \_\_\_\_\_

### **MEDICAL HISTORY:** Please mark off any of the following that pertains to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Hospitalized or Major Surgery; If yes, please explain: _____                      |   |
| <input type="checkbox"/> Bisphosphonate drugs for osteoporosis/cancer                                      | <input type="checkbox"/> Tobacco            |
| <input type="checkbox"/> Antibiotic Premedication for dental treatment                                     | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Blood Thinners  |   |
| <input type="checkbox"/> Medications / Vitamins/ Supplements (Prescribed & Over the Counter); Please List: |   |
- \_\_\_\_\_

### **ALLERGIES:** Are you allergic to any of the following?

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Latex   |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine           | <input type="checkbox"/> Other:  |

**WOMEN ONLY:** Are you.....

Pregnant; Due Date: \_\_\_\_\_

Nursing

Trying to get pregnant

Taking Birth Control

**MEDICAL CONDITIONS:**

Chest Pain

Heart Disease

Heart Murmur

Heart Pacemaker

Mitral Valve Prolapse

Artificial Heart Valve

High Blood Pressure

Stroke

Joint Replacement: \_\_\_\_\_

Diabetes Type \_\_\_\_\_

Glaucoma

Seizures / Epilepsy

COPD / Emphysema

Asthma

Sleep Apnea

Thyroid Disease

Autoimmune Disease

Cancer: \_\_\_\_\_

GERD / Acid Reflux

Headaches/ Migraines

Chemotherapy

Hepatitis: \_\_\_\_\_

Fainting/ Vertigo

Radiation Therapy

Kidney Disease

Liver Disease

Tumors

Arthritis

Osteoporosis

HIV/ AIDS

Tuberculosis

Bleeding Disorder

Depression

Alzheimers/ Dementia

Hearing Impaired

Anxiety

ADHD

Autism

PTSD

Cold Sores

Sinus Issues / Surgery

Other: \_\_\_\_\_

**LIFESTYLE:** Do you use/ consume any of the following?

Tobacco, type: \_\_\_\_\_

Alcohol

Recreational Drugs

**DENTAL INSURANCE INFORMATION:**

Dental Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Primary Insurance Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_

(Secondary) Dental Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Secondary Insurance Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_

**CONSENT & SIGNATURE:**

**NOTE:** By signing below I, \_\_\_\_\_, certify the information provided is accurate and complete to the best of my knowledge. I understand that providing incorrect, or omitting, information, could affect my dental treatment.

**CANCELLATION POLICY:** Our office is committed to providing quality dental care and reserving appointment times specifically for each patient. Missed appointments, late cancellations, and no-shows limit our ability to care for other patients. By signing, you acknowledge the following:

- We request at least 24 hours notice to cancel an appointment. Cancelling less than this may be subject to a cancellation fee of **\$50**.
- Repeated missed appointments may result in limited scheduling availability or dismissal from the practice.
- Patients arriving late may need to reschedule if there is insufficient time remaining for treatment.

**HIPAA ACKNOWLEDGEMENT:** I understand that as part of my healthcare, this dental office originates and maintains health records describing my health history, symptoms, examination results, diagnoses, treatment, and any future care or treatment that may be used among other healthcare professionals involved in my care.

I have been provided with a copy of the dental office's Notice of Privacy Practices (laminated page), which describes how my health information may be used and disclosed.

By signing below, I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_

**PHOTO RELEASE:** (OPTIONAL) I authorize Scheier & Price Family Dentistry to take photographs, videos and/or use dental x-rays of me for purposes related to education & marketing on their website or social media.

INITIAL: \_\_\_\_\_