Time 10:04 AM | White River Family Dental P.C. | Date 9/22/2015

Medical History Form (New) 2015(Copy)

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Have you been out of the country within that last 6 months?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

I understand to the best of my knowledge, these questions have been accurately answered. ☐

WHITE RIVER FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

I consent for disclosure of my Protected Health Information, including my name, diagnosis(es), test results and dates of service.

You may disclose information to the following family members and/or non-family members:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

You may leave Protected Health Information on my answering machine/voicemail. **YES**_____ **NO**_____

Phone Number:_____ Additional Phone Number:_____

Email address _____

_____ _____

Patient's Printed Name **Patient's Date of Birth**

_____ _____

Patient's Signature (Parent or Guardian) **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other (Please Specify)

_____

_____

Date

PATIENT REGISTRATION

Patient's Name _____ Birthdate _____ Sex ❑ M ❑ F

Patient's Address _____ Phone _____
Street City Zip

Patient's Employer _____ Business Address _____ Phone _____

No. of Years Employed _____ Soc. Sec. No. _____ Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Name of Spouse _____ No. of Dependents _____ Spouse's Soc. Sec. No. _____

Spouse's Employer _____ Whom May We Thank For Referring You _____

Nearest Neighbor or Relative's Name, Address, and Phone No. _____

Who Will Pay This Account? (Whose Name Will Appear on Billing Statement)
❑ Self ❑ Spouse ❑ Parent or Guardian

If you checked "self", please skip next section, and continue with Insurance Section

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Parent's or Responsible Party's Names _____ Birthdate _____ Sex ❑ M ❑ F

Street Address (If Dif. Than Above) _____ Phone _____
Street City State Zip

Responsible Party's Employer _____ No. of Years Employed _____ Soc. Sec. No. _____

Business Address _____ Phone _____

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Subscriber's Employer _____ Business Address _____ Insurance Co. _____

Group No. _____ Deductible ❑ Yes ❑ No Max. Benefit _____ Benefit Year _____

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Dependent Have You Used Your Dental Insurance Previously? ❑ Yes ❑ No

Are You Covered Under More Than One Dental Plan? ❑ Yes ❑ No If Yes, Please Fill Out Next Section

SECONDARY INSURANCE

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Insurance Co. _____ Group No. _____ Employer _____ Relationship to Patient _____

(Please continue on next page)

FOR OFFICE USE ONLY

Primary Subscriber's Name _____ Family Member No. _____ Emp. No. _____

Secondary Subscriber's Name _____ Family Member No. _____ Emp. No. _____

Doctor _____

Medical Message

1 No Message 2 See Medical 3 Premedicate 4 See Medical and Premedicate 5 Allergies