
## Patient Information

Today's Date ____ / _____ / ____

Last Name_____ First Name_____ Middle Name _____

Address _____

City_____State_____ Zip code_____

Cell/Home Tel_____Email_____

Social Security number_____Date of Birth _____Sex M F

Employer _____

Emergency Contact Name_____ Telephone_____

How do you plan to settle your account? Cash Check Mastercard Visa Other

## Dental History

Are you having Dental Pain? Yes No
Do you have difficulty eating? Yes No
Are you interested in Dental Implants to stabilize dentures? Yes No

When was your last Dental Visit?_____

What are your main Dental concerns and what brings you in today?_____

_____

## Health History

FOR THE FOLLOWING QUESTIONS, CIRCLE YES OR NO, WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Are you in good health ? Yes No
Have you had any serious illnesses, operations or hospitalizations in the past five years? Yes No

My last physical exam was on: _____

Physician's name and Phone Number: _____

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

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Hemophilia | Yes | No |
| Alzheimer's Disease | Yes | No | Hepatitis A | Yes | No |
| Anaphylaxis | Yes | No | Hepatitis B or C | Yes | No |
| Anemia | Yes | No | Herpes | Yes | No |
| Angina | Yes | No | High Blood Pressure | Yes | No |
| Arthritis/Gout | Yes | No | High Colesterol | Yes | No |
| Artificial Heart Valve | Yes | No | Hives or Rash | Yes | No |
| Artificial Joint | Yes | No | Hypoglycemia | Yes | No |
| Asthma | Yes | No | Irregular Heartbeat | Yes | No |
| Blood Disease | Yes | No | Kidney Problems | Yes | No |
| Blood Transfusion | Yes | No | Leukemia | Yes | No |
| Breathing Problems | Yes | No | Liver Disease | Yes | No |
| Bruise Easily | Yes | No | Low Blood Pressure | Yes | No |
| Cancer | Yes | No | Lung Disease | Yes | No |
| Chemotherapy | Yes | No | Mitral Valve Prolapse | Yes | No |
| Chest Pains | Yes | No | Osteoporosis | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Pain in Jaw Joints | Yes | No |
| Congenital Heart Disorder | Yes | No | Parathyroid Disease | Yes | No |
| Convulsions | Yes | No | Psychiatric Care | Yes | No |

| | | | | | |
|---|---|---|---|---|---|
| Cortisone Medicine | Yes | No | Radiation Treatments | Yes | No |
| Diabetes | Yes | No | Recent Weight Loss | Yes | No |
| Drug Addiction | Yes | No | Renal Dialysis | Yes | No |
| Easily Winded | Yes | No | Rheumatic Fever | Yes | No |
| Emphysema | Yes | No | Rheumatism | Yes | No |
| Epilepsy or Seizures | Yes | No | Scarlet Fever | Yes | No |
| Excessive Bleeding | Yes | No | Shingles | Yes | No |
| Excessive Thirst | Yes | No | Sickle Cell Disease | Yes | No |
| Fainting Spells/Dizziness | Yes | No | Sinus Trouble | Yes | No |
| Frequent Cough | Yes | No | Spina Bifida | Yes | No |
| Frequent Diarrhea | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Frequent Headaches | Yes | No | Stroke | Yes | No |
| Genital Herpes | Yes | No | Swelling of Limbs | Yes | No |
| Glaucoma | Yes | No | Thyroid Disease | Yes | No |
| Hay Fever | Yes | No | Tonsilitis | Yes | No |
| Heart Attack/Failure | Yes | No | Tuberculosis | Yes | No |
| Heart Murmur | Yes | No | Tumors or Growths | Yes | No |
| Heart Pacemaker | Yes | No | Ulcers | Yes | No |
| Heart Trouble/Disease | Yes | No | Venereal Disease | Yes | No |

**Medications**

Please list all medications (prescribed or over-the-counter)and what they are for:

_____

_____

Are you allergic to any medications? Yes No
(If yes, please complete below)

Penicillin Sulfa drugs Local anesthetic Latex or rubber other_____

Are you taking or have you ever taken Bisphospho-nates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa Yes No

Are you taking any anticoagulant/blood thinner (aspirin, Eliquis, etc): Yes No
Have you recently stopped taking an anticoagulant/blood thinner – if so for how long? _____
Are you taking Reflx/Proton pump inhibitors (eg Prilosec): Yes No
Are you taking any SSRIs/Antidepressants (Prozac, Zoloft): Yes No
Are you taking Beta blocker Blood pressure meds (end in -ol): Yes No
Do you have an Autoimmune Disease (eg Lupus): Yes No
Do you have Diabetes Yes No

- If yes what is your HbA1c: _____ and Blood Glucose: _____

Do you smoke or use other tobacco products Yes No
Do you Vape Yes No
Do you Dip Yes No

- If Yes, How many packs/cartridges per day? _____

Do you drink alcohol Yes No

- If yes how frequently?_____

Do you use marijuana or other "street" drugs Yes No

- If Yes, how frequently? _____

Do you get headaches or tooth aches in the morning from clenching or grinding? Yes No

**Other**

Do you have any other disease, condition or problem not listed above that you think the doctor should know about Yes No
Do you wish to talk with the doctor privately about anything? Yes No

**Women**

Are you pregnant, or could you be pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control pills? Yes No

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

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Signature of person completing health history Doctor's Initials

FINANCIAL AGREEMENT

____ We believe it is important to provide affordable high quality Dental services. For your convenience, we accept MasterCard, Visa, American Express, and Debit Cards. We also offer Care Credit as a financing option. As it may be difficult to complete financial transactions following surgery and anesthesia, we respectfully

request that your account be settled prior to your surgery. We are proud that our fees reflect the individualized service and care that we provide and hope that your experience exceeds your expectations.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the office's Notice of Privacy Practices and have had the opportunity to discuss the policies with staff. Quality Dentures & Implants provides this form to comply with HIPPAA requirements. Please review the Notice of Privacy Practices before signing this document.

By signing this form, you acknowledge that we may use and disclose your protected health information for treatment, payment, and healthcare operations. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment and healthcare operations.

_____ _____

*Signature of Patient or Legally Authorized Representative* *Date*

_____ _____

*Print Name of Patient or Legally Authorized Representative* *Legal Relationship to Patient*

**I give permission for Quality Dentures & Implants to:**

- Call/leave message at my home telephone number: _____
- Call/leave message/text on my mobile number: _____
- Call/leave message on my work number: _____
- Send me an unencrypted email:_____
- Other: _____

**I give permission for you to speak with these individuals about my care:**
(Note: Please notify us if you wish to make a change in the future.)

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

----------Office Use Only ----------

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

- Patient/Representative refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement

- Other (Please Specify): _____

_____