Autumn Ridge Dental

HEALTH HISTORY

To our patients: Although dentists primarily treat the area in & 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 care that you will be receiving. Thank you for answering the following questions. Your answers are for our records & will be considered confidential.

Patient's name:_______________________________ Birthdate:_______________

DENTAL HISTORY

Reason for Today's visit:____

Date of last dental care:____________________ Date of last dental x-rays:____________________

Have you ever used nitrous oxide (happy gas) before? ....❑ Yes ❑ No Would you like to use nitrous oxide (happy gas)? .... ❑Yes ❑ No

Have you had any serious problems with previous dental treatment?..... ❑ Yes ❑ No Do you have a removable dental appliance? .... ❑Yes ❑No

Have you had excessive bleeding following tooth extractions, surgery, or injury?........... ❑ Yes ❑ No

Name of former dentist and address: ____

MEDICAL HISTORY

Physician's Name and phone #:______________________________ Date of last visit:_______________

Have you had any serious illnesses or operations in the past 5 years? .... ❑Yes ❑No
If yes, describe:____
Do you have unhealed/recurrent or inflamed areas, growths or sore spots in or around your mouth? ....❑Yes ❑No
If yes, describe:____
Do you have a prosthetic joint/implant? ....❑Yes ❑No
If yes, describe:____
Have you had a heart valve replacement or vascular graft? .... ❑Yes ❑No

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS:

❑Yes ❑No Anemia	❑Yes ❑No Cough, Persistent	❑Yes ❑No High Blood Pressure	❑Yes ❑No Seizures
❑Yes ❑No Arthritis, Rheumatism	❑Yes ❑No Cough up Blood	❑Yes ❑No History of drug abuse	❑Yes ❑No Sexually transmitted diseases
❑Yes ❑No Artificial Heart Valves	❑Yes ❑No Diabetes	❑Yes ❑No HIV / AIDS	❑Yes ❑No Shortness of Breath
❑Yes ❑No Artificial Joints	❑Yes ❑No Dialysis	❑Yes ❑No Jaw Pain	❑Yes ❑No Sinus Problems
❑Yes ❑No Asthma	❑Yes ❑No Difficulty Breathing	❑Yes ❑No Kidney Disease	❑Yes ❑No Skin Rash
❑Yes ❑No Autism	❑Yes ❑No Emphysema	❑Yes ❑No Liver Disease	❑Yes ❑No Snoring/Sleep apnea
❑Yes ❑No Back Problems	❑Yes ❑No Epilepsy	❑Yes ❑No Low Blood Pressure	❑Yes ❑No Stroke
❑Yes ❑No Bleeding Tendency	❑Yes ❑No Fainting	❑Yes ❑No Mental Health problems	❑Yes ❑No Swelling of Feet/ Ankles
❑Yes ❑No Blood Disease	❑Yes ❑No Glaucoma	❑Yes ❑No Mitral Valve Prolapse	❑Yes ❑No Thyroid Problems
❑Yes ❑No Chemical Dependency	❑Yes ❑No Headaches	❑Yes ❑No Osteoporosis/Osteopenia	❑Yes ❑No Tobacco Habit
❑Yes ❑No Cancer	❑Yes ❑No Heart Attack(s)	❑Yes ❑No Pacemaker	❑Yes ❑No Tonsillitis
❑Yes ❑No Chemotherapy	❑Yes ❑No Heart Murmur	❑Yes ❑No Radiation Treatment	❑Yes ❑No Tuberculosis
❑Yes ❑No Circulatory Problems	❑Yes ❑No Heart Problems	❑Yes ❑No Respiratory Disease	❑Yes ❑No Tumor/Growth
❑Yes ❑No Contagious diseases	❑Yes ❑No Hemophilia	❑Yes ❑No Rheumatic Fever	❑Yes ❑No Ulcer
❑Yes ❑No Cortisone Treatments	❑Yes ❑No Hepatitis Type ___	❑Yes ❑No Scarlet Fever	❑Yes ❑No Venereal Disease

MEDICATIONS

Pharmacy Name:____________________ Phone Number ____________________

Are you currently taking any kind of medication, drug, pills? ....❑Yes ❑No
Are you currently taking any blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)? ....❑Yes ❑No
Have you taken diet pills? .... ❑Yes ❑No
Any natural product, herbal supplement or homeopathic remedy? .... ❑Yes ❑No
Have you taken any bone density medications/Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)? .... ❑Yes ❑No

Please list any medications are currently taking:____

____

____

____

____

ALLERGIES

Are you allergic to, or had a reaction to....

Local anesthetic (numbing medicine)? .... ❑Yes ❑No
Penicillin? .... ❑Yes ❑No
Other antibiotics? .... ❑Yes ❑No
Sulfa Drugs? .... ❑Yes ❑No
Aspirin? .... ❑Yes ❑No
Codeine or other narcotics? .... ❑Yes ❑No
Latex? .... ❑Yes ❑No
Sulfites? .... ❑Yes ❑No

Please list any other medications & other allergies that you have:______________________________

____

____

THIS SECTION IS FOR WOMEN ONLY, MEN CONTINUE BELOW.

Is there a possibility of pregnancy? .... ❑Yes ❑No
Expected delivery date _______/_______/__________
Are you nursing? .... ❑Yes ❑No
Are you taking birth control pills? .... ❑Yes ❑No

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

IN CASE OF EMERGENCY, CONTACT:

Name______________________________ Relationship ______________________________

Home Tel.______________________________ Cell______________________________ Work______________________________

PLEASE READ AND SIGN BELOW

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any of his staff responsible for any errors or omissions that I have made in the completion of this form.

X______________________________ X______________________________ X______________________________

*Patient **OR** Parent/Guardian signature* *Today's Date* *Reviewed By*

Authorization

I authorize my dentist and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X______________________________ X______________________________ X______________________________

*Patient **OR** Parent/Guardian signature* *Today's Date* *Reviewed By*

Privacy Policy

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X______________________________ X ______________________________

*Patient **OR** Parent/Guardian signature* *Today's Date*

For office use only:

Future updates by Patient OR Parent/Guardian

X______________________________ **X**______________________________ **X**______________________________

*Patient **OR** Parent/Guardian signature* *Today's Date* *Reviewed By*

X______________________________ **X**______________________________ **X**______________________________

*Patient **OR** Parent/Guardian signature* *Today's Date* *Reviewed By*

Form edited 12/2016