PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP Heart Rate:

Height:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding/Bruising
☐	☐	Alcohol/Drug Abuse
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Cold Sores/Canker Sores
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes/Hypoglycemia
☐	☐	Difficulty Breathing
☐	☐	Dry Mouth
☐	☐	Emphysema
☐	☐	Epilepsy/Seizures
☐	☐	Fainting Spells
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ Or AIDS
☐	☐	Hay Fever
☐	☐	Heart Murmur
☐	☐	Heart Problems Of Any Type
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Implants Of Any Type
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Nervous Problems
☐	☐	Pace Maker
☐	☐	Persistent Cough
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Snoring

Y	N	Conditions
☐	☐	Stroke
☐	☐	Swollen Lymph Nodes
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Unexplained Weight Loss

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

PERSONAL INFORMATION

PATIENT'S NAME _____
LAST FIRST MIDDLE

CELL PHONE# (_____)_____

PATIENT'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

OCCUPATION _____

SPOUSE'S NAME _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ EMPLOYER ADDRESS _____

PERSON RESPONSIBLE FOR ACCOUNT _____

ADDRESS _____

IF MINOR OR FULL-TIME STUDENT:

FATHER'S NAME _____ EMPLOYER _____

MOTHER'S NAME _____ EMPLOYER _____

FULL-TIME STUDENT? YES NO WHERE? _____

DO YOU HAVE TITLE XIX? YES NO

DO YOU HAVE DENTAL INSURANCE? YES NO ……IF YES, COMPLETE THE FOLLOWING:

PRIMARY INSURANCE _____ _____
SUBSCRIBER (PERSON WHO CARRIES INS) INSURANCE COMPANY

_____ _____
SUBSCRIBER'S BIRTHDATE SOCIAL SECURITY # OF SUBSCRIBER

SECONDARY INSURANCE _____ _____
SUBSCRIBER (PERSON WHO CARRIES INS) INSURANCE COMPANY

_____ _____
SUBSCRIBER'S BIRTHDATE SOCIAL SECURITY # OF SUBSCRIBER

OTHER THAN THE NAMES ABOVE, WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

NAME _____ RELATIONSHIP _____

PHONE # _(_____)_____

WHOM DO WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

I, THE UNDERSIGNED, AFFIRM THE INFORMATION GIVEN ON THIS FORM TO BE ACCURATE. THIS INFORMATION WILL BE UTILIZED FOR EVALUATION AND TREATMENT BY THE DENTISTS OF FLEUR DENTISTRY, LLP.

DATE _____ SIGNATURE _____ DR INITIAL _____

DENTAL HISTORY

PATIENT'S NAME _____ DATE _____

1. HAVE YOU NOTICED ANY OF THE FOLLOWING?

GRINDING OR CLENCHING TEETH	YES	NO
FOOD CATCHING BETWEEN TEETH	YES	NO
TEETH TENDER WHEN CHEWING	YES	NO
TEETH SENSITIVE TO HOT, COLD, OR SWEETS	YES	NO
BLEEDING GUMS WHEN BRUSHING	YES	NO
BLEEDING GUMS WHEN FLOSSING	YES	NO
SWELLING OR SORES IN MOUTH	YES	NO
PAIN IN TEETH OR JAWS	YES	NO

2. HAVE YOU EVER HAD YOUR TEETH STRAIGHTENED? YES NO

3. WOULD YOU LIKE TO KEEP YOUR NATURAL TEETH? YES NO

4. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE? (GUM DISEASE) YES NO

5. DO YOU USE ANY TOBACCO PRODUCTS? YES NO

6. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES NO
   IF NO, PLEASE EXPLAIN

   _____

7. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

8. HOW OFTEN DO YOU FLOSS YOUR TEETH? _____

9. HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES NO
   IF YES, PLEASE EXPLAIN _____

10. APPROX DATE OF LAST CLEANING _____ LAST DENTAL TREATMENT _____

11. PREVIOUS DENTIST _____ PHONE _____
    CITY _____ STATE _____

12. WHY DID YOU LEAVE YOUR LAST DENTIST? _____

13. WHAT DID YOU LIKE MOST ABOUT YOUR LAST DENTIST? _____

    _____

14. WHAT DID YOU LIKE LEAST ABOUT YOUR LAST DENTIST? _____

    _____

15. DO YOU HAVE ANY CONCERNS YOU WOULD LIKE EVALUATED TODAY? YES NO
    IF YES, PLEASE EXPLAIN _____

    _____

FLEUR DENTISTRY

Date: _____

Patient Name: _____

Date of birth: _____

Please circle Yes or No.

1) Do you snore or have you been told that you snore? Yes No

2) Have you been told that you stop breathing or gasp during sleep? Yes No

3) Are you sleepy during the day? Yes No

If you answered yes to any of the above questions, please answer the following:

4) Are you being treated for high blood pressure? Yes No

5) Do you often wake in the morning with a headache? Yes No

6) Do you often wake up with a dry mouth? Yes No

7) Do you grind or clench your teeth in your sleep? Yes No

8) Do you feel pain in your jaw joints (area of the ear)? Yes No

9) Have you ever been diagnosed with sleep apnea? Yes No

10) Have you ever had a sleep study? Yes No

If yes, when and where? _____

11) Are you being treated for sleep apnea? Yes No

Height: _____ Weight: _____ Neck circumference: _____

Patient Signature: _____

FLEUR DENTISTRY, L.L.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____

{Please Print Name}

_____

{Signature}

_____

{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 acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

FLEUR DENTISTRY, L.L.P.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: KERRY

Telephone: 515-287-2493 Fax: 515-287-7948

E-mail: info@fleurdentistry.com

Address: 4551 Fleur Drive Des Moines, IA 50321-2331

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 heath care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____