

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:
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**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_  
LAST FIRST MIDDLE  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
P.O. BOX or Mailing Address  
 Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M  F   
 SS#: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person?  
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

**DENTAL INFORMATION**

	Yes	No	Don't Know	
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How would you describe your current dental problem? _____
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____
Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How do you feel about the appearance of your teeth? _____
Have you had a serious/difficult problem associated with any previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, explain: _____				

**MEDICAL INFORMATION**

	Yes	No	Don't Know	
<b>If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.</b>				
Have you had any of the following diseases or problems?				Are you taking or have you recently taken any medicine(s) including non-prescription medicine? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Active Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				If yes, what medicine(s) are you taking? _____
Persistent cough greater than a 3 week duration <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Prescribed: _____
Cough that produces blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Over the counter: _____
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Vitamins, natural or herbal preparations and/or diet supplements: _____
Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what is/are the condition(s) being treated? _____				If yes, how much alcohol did you drink in the last 24 hours? _____
_____				In the past week? _____
Date of last physical examination: _____				Are you alcohol and/or drug dependent? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician: <small>NAME PHONE</small> _____				If yes, have you received treatment? (circle one) Yes / No
<small>ADDRESS CITY/STATE ZIP</small> _____				Do you use drugs or other substances for recreational purposes? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<small>NAME PHONE</small> _____				If yes, please list: _____
<small>ADDRESS CITY/STATE ZIP</small> _____				Frequency of use (daily, weekly, etc.): _____
Have you had any serious illness, operation, or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Number of years of recreational drug use: _____
If yes, what was the illness or problem? _____				Do you use tobacco (smoking, snuff, chew)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____				If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested
_____				Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____				

	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To yes responses, specify type of reaction. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was this operation done?	_____		
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?	_____		
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what antibiotic and dose?	_____		
Name of physician or dentist*:	_____		
Phone:	_____		

**WOMEN ONLY**

	Yes	No	Don't Know
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion. If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Angina			
___ Arteriosclerosis			
___ Artificial heart valves			
___ Congenital heart defects			
___ Congestive heart failure			
___ Coronary artery disease			
___ Damaged heart valves			
___ Heart attack			
___ Heart murmur			
___ High blood pressure			
___ Low blood pressure			
___ Mitral valve prolapse			
___ Pacemaker			
___ Rheumatic heart disease/Rheumatic fever			
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type I (Insulin dependent)			
___ Type II			
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't Know
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, indicate type of infection: _____			
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Emphysema			
___ Bronchitis, etc.			
Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores or ulcers in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain:	_____		

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

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

SIGNATURE OF PATIENT/LEGAL GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments on patient interview concerning health history: \_\_\_\_\_  
 \_\_\_\_\_

Significant findings from questionnaire or oral interview: \_\_\_\_\_  
 \_\_\_\_\_

Dental management considerations: \_\_\_\_\_  
 \_\_\_\_\_

**Health History Update:** On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____
_____	_____	_____

**PARTNERS IN ORAL HEALTH**

**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: Virginia Gavis, DMD

Telephone: (617) 527-0880 Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

**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.

**PRINT**

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 health 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.**

# PARTNERS IN ORAL HEALTH

The following are POH policies. Please read over our policies and initial in the space provided. Also please print and sign your name in the space provided at the bottom of the page.

## 1. APPOINTMENTS

We make every effort to accommodate the needs of our patients. Appointment lengths vary depending on the provider. Although we call to remind you of your appointment we expect that you show up for your scheduled time unless you have given us adequate notice to either cancel or reschedule.

\_\_\_\_\_

## 2. INSURANCE

We bill your insurance for any services as a courtesy to you. However, you are responsible for anything insurance does not cover. You are required to update our office with any changes to your insurance coverage.

\_\_\_\_\_

## 3. BILLING

Payment is required at the time of service unless other arrangements have been made prior to your appointment. If you have dental insurance coverage, we reserve the right to collect any deductible or co-insurance at the time of your visit.

\_\_\_\_\_

## 4. CANCELLATION POLICY

Your scheduled appointment is a time that has been reserved specifically for you. If for any reason you are unable to keep your appointment we kindly ask for 48 hours notice. We reserve the right to charge for any missed appointment or cancellation without 48 hours notice.

\_\_\_\_\_

Name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_