Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

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

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics _____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals _____ ☐ ☐ ☐
Latex (rubber) _____ ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals _____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

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

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date: _____
Hemophilia ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐
Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
If yes, specify: _____
Sleep disorder ☐ ☐ ☐
Do you snore? ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Specify: _____
Recurrent Infections ☐ ☐ ☐
Type of infection: _____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands in neck ☐ ☐ ☐
Severe headaches/ migraines ☐ ☐ ☐
Severe or rapid weight loss ☐ ☐ ☐
Sexually transmitted disease ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Bruce A. Hester, D.M.D
2980 Lewis Street
Kennesaw, GA 30144
770-422-1554

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:_____

Address:_____

Phone 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 healthcare information to carry out treatment, payment activities, and healthcare operations. You may obtain a copy of our Notice of Privacy Practices by contacting our office.

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 health information. A copy of our Notice may accompany this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices at any time. If any changes are made, we will issue a revised notice, which will contain those changes which may apply to any of your protected health information that we maintain.

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice. Please understand that revocation will not affect any action we took in reliance on this consent and that we may decline to treat, or continue treating you based on your revocation.

Signature: (If under 18, Parent/Guardian Signature)

I, _____, had full opportunity to read and consider the contents of this consent form and the 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 healthcare operations.

Signature:_____

Date:_____

Bruce A.Hester D.M.D.
2980 Lewis St. Kennesaw, GA 30144
770-422-1554

Financial Policy

In our continued commitment to provide the highest quality dental care to all of our patients while offering affordable services, we are pleased to offer the following financial options:

We accept: ❖ Cash or Check **All major credit cards:** ❖ Visa ❖ Discover ❖ Mastercard ❖ American Express	We are pleased to offer three additional financial options for your convenience: ➢ **Wells Fargo** ➢ **Care Credit** ➢ **Lending Club** *Please ask our administrative staff for details and credit applications

We are committed to support you in understanding your dental health so that you will be able to make the best, most informed decisions.
We will, as a courtesy, process your insurance on your behalf at the time of your visit. Please understand that this is an estimation and having dental insurance does not relieve you of your financial responsibility

I agree that I am fully responsible for the total payment for all procedures - this includes, but is not limited to, any treatment that is not a covered benefit of any dental insurance benefits I may have. I acknowledge that **all services are to be paid in full at the time services are rendered**. If my insurance company denies payment on a claim for any reason, I understand that it is my responsibility to pay the balance of that claim within 10 days of the denial. Insurance will be filed for primary coverage only. If you have secondary insurance it is your responsibility to ask for the appropriate forms so that you may file the claim. Patients without dental insurance are expected to pay the balance in full when services are rendered. Financial arrangements are available through Care Credit, Lending Club and Wells Fargo.

We reserve the right to take legal action on any delinquent account to include but not limited to turning the account over to a collection agency, reporting the delinquency to the credit bureau and if necessary, filing suit. A **$25 fee** will be applied to all returned checks

We are here to assist you in any way possible. Please make your questions and concerns known to one of our team members. Our goal is to ensure that you have an outstanding experience.
I have read, understand and agree to all the terms above.

_____ _____

Print Patient Name **Signature** (Parent or Guardian if under 18)

_____

Date

INVERNESS
APOTHECARY

Delivery of Medication to Prescriber's Office Consent Form

Patient:

I consent that my prescribed medication may be delivered to the prescriber's office.

Name: _____ Date of Birth: _____
Last First Middle

Patient Signature: _____ Date: _____

Health Care Provider:

Prescriber's Name: _____

Phone: _____ Fax: _____

Email: _____

A copy of this consent form must accompany the patient's prescription.