Adult Medical History

Demographics

Name: _____ Date of Birth: _____

☐ **DEMOGRAPHIC INFORMATION BELOW HAS NOT CHANGED**

Mailing Address: _____

City: _____ State and Zip: _____

Cell Phone Number: _____

Home/Work Phone Number: _____

With which phone number do you prefer to be contacted? (Please circle) CELL HOME WORK

Email Address: _____

Employer: _____ Phone Number: _____

Referred by: _____

Previous Dental Information

If not with us, when was your last dental cleaning and exam? _____

Do you have, or have you ever experienced, dental anxiety? _____

Pre-medication

Do you need to take an antibiotic pre-medication for dental procedures? _____

If so, what antibiotic have you been taking for pre-medication? _____

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Allergies and Pregnancy

Are you sensitive or allergic to: ☐ Penicillin ☐ Codeine Tetracycline ☐ Erythromycin ☐ Sulfa Drugs ☐ Metals ☐ Latex ☐ Sedatives ☐ Dental Anesthetics ☐ Other:_____

Describe reaction: _____

Are you allergic to any other medications, drugs or treatments? _____

WOMEN: Are you pregnant?_____ Due Date:_____ Are you nursing?_____

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Medical Information

Primary Physician: _____ Phone Number: _____

Are you currently under a doctor's care (other than primary care)? _____

If yes, please describe: _____

Have you been hospitalized or had any surgeries in the last 5 years? _____

If yes, please list treatment and/or surgery: _____

Do you smoke? ○ Yes ○ No Packs per day: _____ How long? _____

Do you use alcohol? ○ Yes ○ No How often? _____

Do you use marijuana? ○ Yes ○ No How often? _____

Do you use chewing tobacco? ○ Yes ○ No How often? _____

Do you use nicotine pouches/ vape pens? ○ Yes ○ No How often? _____

Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications (taken for osteoporosis, chemotherapy, etc)? _____

If yes, how long? _____ Please indicate which medication: ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Other

If other, please list medication: _____

Are you taking any drugs or medications at this time? ○ Yes ○ No

Current medications you are taking:

Please note:

It is VERY important that you let our office know if you are taking the following:

- BLOOD THINNERS
- IMMUNOSUPPRESSANTS
- CHEMOTHERAPY MEDICATION

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Medical Conditions

Do you have or have you experienced any of the following? Please check all that apply.

- ☐ AIDS/HIV
- ☐ Abnormal Bleeding
- ☐ Alcohol Addiction
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Pins, Bones or Joints
  - When: _____
  - Where: _____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer/Tumors
  - List Type: _____
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
  - Type: _____
- ☐ Difficulty Breathing
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Attack
  - Date: _____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
  - Type of surgery: _____
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  - Disorder: _____
- ☐ Osteoporosis
- ☐ Pacemaker
  - Date Placed: _____
  - Type placed: _____
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke/CVA
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Other

Please list any serious medical conditions(s) not indicated above that you have experienced in the last 5 years:

_____

Emergency Contact: _____ Phone: _____ Relationship: _____

If you authorize someone else that we can share your private health information with, please list them below:

_____

_____

By signing this form, I acknowledge that the information provided is true and accurate to the best of my knowledge.

Patient Signature:

X _____

_____

Signer's Full Name **Date**

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General Consent for Treatment and Local Anesthesia

While serious complications associated with dental procedures are very rare, we would like you to be informed about necessary procedures in dentistry and your consent before beginning treatment. The following risks and or complications exist with dental treatments.

Complications: resulting from the use of dental injections and anesthetics include and are not limited to:

- Swelling at site of injection
- Bleeding at site of injection
- Infection at site of injection
- Discomfort at site of injection
- Prolonged numbness and tingling sensation in oral cavity. these sensations are usually temporary, but can be permanent
- Jaw muscle cramps and spasms
- Jaw joint difficult or pain radiating to head, neck and ear
- Nausea and vomiting
- Allergic reaction
- Rapid or irregular heartbeat
- Biting of the cheek, lip and tongue after treatment resulting in swelling and discomfort

Complications from medications or prescription medication given in the office are common. To decrease your risk of a potentially serious drug reaction, please provide us with the knowledge of any past/current drug allergies or adverse reactions. In addition we are careful about the medications we prescribe and will not prescribe a medication unless it is absolutely necessary:

Allergic reaction- itching, swelling, difficulty breathing *ƒ*
Adverse reactions- nausea, vomiting, headache, drowsiness

Depending on the procedure, minor to moderate sensitivity of the teeth are soreness of the gums in the area that was treated is completely normal. If you have any questions or concerns after care, please do not hesitate to call our office.

I have read and understand this form and give general informed consent for dental treatment.

_____ _____

Patient's signature Date

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an “Appointment Cancellation Policy” that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient (we do not double book our appointment times).

Our policy is as follows:

We require that you give our office at least **24 hours’ notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment, if possible. We do everything within our power to make you aware of an appointment ahead of time and give you the opportunity to confirm or reschedule. So if you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A cancellation fee of $50.00 will be charged to you otherwise; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment and we are unable to get ahold of them via text or phone call, we will consider this a missed appointment and the $50.00 cancellation fee will be charged. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient/Guardian Signature **Date**

Consent for Use and Disclosure of Health Information

Our notice of Privacy Practices provides information about how we might use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of the notice may change at any time, at which point you will be asked to sign this form again. You have the right to obtain a copy of our notice at any time.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. You have the right to revoke this Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Main Street Dental provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as the Health Information Technology for Economic and Clinical Health Act (HITECH) and the final Omnibus Ruling of 2013.

<u>The patient understands that:</u>

Main Street Dental has a Notice of Privacy Practices and the patient has the opportunity to review this notice, and obtain a copy from the clinic.

Protected health information may be disclosed or used for treatment, payment, or health care operations, as needed.

Main Street Dental reserves the right to change the Notice of Privacy Practices, and must obtain an updated patient signature to illustrate their understanding the change has taken place.

The patient has the right to restrict the uses of their information, but Main Street Dental does not have to agree to those restrictions if it can impede upon the practice's ability to treat the patient, collect payment, or to avert a serious threat to health or safety (either to the patient or to others).

Main Street Dental may condition treatment upon execution of this consent.

Please contact Dr. Seth Monson to review any concerns or issues you may have with Main Street Dental's notice, at (503) 665-8283.

Signature:_____ Date:_____

Patient or Guardian of Patient