MEDICAL HISTORY

WELCOME

Patient's Name: _____

How do you prefer to be called? _____

Age _____ Male _____ Female _____

Date of Birth _____

Address _____

_____

Home Phone _____Business _____
Cell # _____

Reason for visit _____

Whom may we thank for the referral? _____

_____

As a courtesy in the future, we would like to remind patients of their dental appointments by e-mail, please list your e-mail address below:

_____

EMERGENCY CONTACT INFORMATION:

Whom May We Contact In Case of An Emergency:

Name: _____

Phone: _____

Relationship to Patient: _____

DENTAL HISTORY

Patient's first dental visit Yes _____ No _____

Previous Dentist _____ Last visit _____

History of:

Dental grinding or clenching _____When _____

Dental Pain _____ When _____

Has the patient experienced any unfavorable reaction from previous medical/dental care? _____

Is there anything you would like to change about your smile? _____

_____

MEDICAL HISTORY

Are you presently under the care of your family physician/specialist for any medical reason?
Yes _____ No _____

If Yes, What? _____

_____

Physician's/Specialist name: _____

Phone #_____ Address_____

_____

Do you have a history of health problems?_____

If yes, explain: _____

_____

Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason? Yes_____ No_____

Are you taking any medications? Yes_____ No ____
If so, please list: _____

_____

_____

_____

_____

_____

Have you had a history or taking medications frequently?
Yes _____ No _____
If so, please list: _____

_____

Have you ever been hospitalized or had surgery?
Yes _____ No _____
For what? _____

Are you allergic to a drug or drug product?
Yes _____ No _____
If yes, what? _____

_____

Are you allergic to any medications, if so please list?

_____

_____

Are you allergic to any dyes, if so please list? _____

_____

Are you allergic to any environmental pollutants? ___

_____

Are you allergic to any foods? _____

_____

Are you allergic to latex, metals, or acrylics? _____

_____

Has any member of the family or you had a problem with general anesthetic?_____

PLEASE CIRCLE ANYTHING THAT PERTAINS TO YOU:

AIDS-HIV
Anemia
Arthritis
Asthma, if yes what triggers it _____
Autism
Bladder Conditions
Blood Disease
Blood Transfusions
Birth Defects
Bone or Joint Problems/Joint Replacement
Brain Injury
Bruising Easily
Cancer or Malignancies
Cerebral Palsy
Chemotherapy Radiation
Child Abuse
Chronic Ear Infections
Cleft Lip/ Palate
Congenital Heart Lesion
Convulsions/Seizures
Developmentally Delayed
Diabetes- Type 1 _____ Type 2 _____
Drug Addiction
Ear Stuffiness, itching, noises
Emotional Disturbance
Epilepsy
Eye Problem
Excessive Bleeding Problem
Excessive Gagging
Fainting or Dizziness
Fever Blisters
Growth & Developmental Problems
Heart Surgery
Headaches
Hearing/ Speech Impairments
Heart Murmur/Defect/Stent
Hemophilia
Hepatitis or Liver Disease
High Blood Pressure
Hyperactivity/ ADD
Kidney Disease
Leukemia
Mental Disability
Mouth Sores
Nutritional Deficiency
Orthopedic Problems
Pain in Jaw Joints
Premature Birth
Psychiatric Care
Rheumatic Fever
Scoliosis
Sickle Cell Anemia
Smoker
Syndrome _____
Tuberculosis
Other _____

PREVENTIVE DENTAL HISTORY- FOR MINOR PATIENTS ONLY

How often does your child brush? _____

Is tooth brushing supervised? _____
By whom? _____

Is dental floss used? _____

Does your child receive:
Fluoride in vitamins _____
Fluoride tablets/drops _____
Fluoride water _____
Bottle water _____
Well water _____

RESPONSIBLE PARTY

Full Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Birth Date: _____

Home #: _____ Business/Cell#: _____

Employer: _____

Occupation: _____

PRIMARY INSURANCE INFO:

Policyholder Name: _____

Policyholder SS#: _____

Policyholder Date of Birth: _____

Insurance Name: _____

Insurance Phone#: _____

SECONDARY INSURANCE INFO:

Policyholder Name: _____

Policyholder SS#: _____

Policyholder Date of Birth: _____

Insurance Name: _____

Insurance Phone#: _____

CONSENT TO PROVIDE DENTAL EXAMINATION

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render diagnosis. This would include an oral examination radiographs (X rays) and other diagnostic aids. I have an accurate report of my (or my child's) physical and mental health history, & I have also reported and prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood, or body diseases gum or skin reactions abnormal, bleeding or any other conditions related to my (or my child's) health or any other physical conditions that my (or my child's) medical doctor has advised me should be reported to a dentist.

SIGN _____ **DATE** _____

*****VERY IMPORTANT*****

I am aware that if I **CAN NOT** make my appointment, that I need to call at least **48 hours** ahead of schedule. Also, I am aware that there shall be a $30.00 no show fee if I miss my scheduled appointment and a $50.00 service charge for missing a previously **CONFIRMED** appointment.

SIGN _____ **DATE** _____

FOR DOCTOR USE ONLY

Reviewed by: _____

Significant Findings_____

Medical Alert _____

ASA I II III IV TONSILS I II III IV

Sedation: Child _____ Teen _____ Adult _____ or IV Sedation _____
Does patient have to take medicines before sedation appointment: Yes _____ No _____
Medical Release: Yes _____ No _____
Refer to: _____

ASSISTANT RESPONSIBILITY
Weight:_____
Adult sedation questionnaire done by: _____
Teen sedation questionnaire done by: _____
Consent signed: Yes _____ No _____ Note: _____
Responsible for watching the video: Mom _____ Dad _____ Family member specify _____

FRONT STAFF RESPONSIBILITY

Pre authorization: Yes _____ No _____
Covered by Medicaid: Yes _____ No _____
Insurance: Yes _____ No _____ Catholic Charity _____
Pharmacy & Location: _____

HEALTHY SMILES

215 N. Bowman Road

Little Rock, AR 72211

I have received and/or received a copy of

Healthy Smiles

Notice of Privacy Practices

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

Guarantor Signature _____

Date _____

I authorize the following individuals to act as appointed healthcare representatives with whom my health information may be discussed.

_____

_____

FOR OFFICIAL 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

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

_____ _____

Staff Signature Date