DENTALHOUSE
COME AS PATIENTS, LEAVE AS FAMILY

NEW PATIENT HEALTH HISTORY FORM

PATIENT: [☐ Please check if patient is a minor.] *(PLEASE PRINT CLEARLY)*

Last Name | First Name | Middle Initial | Cell Phone | Home Phone

Street Address | City | State | Zip Code

Birth Date | Age | Employer / School | Occupation / Title | Work Phone / Extension

Driver License Number | Social Security Number | Email Address | Gender: ☐ M ☐ F ☐ Other

SPOUSE: ☐ **Male** ☐ **Female** ☐ **Other**

Last Name | First Name | Middle Initial | Cell Phone | Home Phone

Birth Date | Age | Employer / School | Occupation / Title | Work Phone / Extension

Driver License Number | Social Security Number | Email Address

If PATIENT IS A MINOR, INFORMATION OF RESPONSIBLE PARTY:

Last Name | First Name | Middle Initial | Best Contact Number | Birth Date

Relationship to Patient | Home Address

Driver License Number | Social Security Number | Occupation / Employer | Gender: ☐ M ☐ F

DENTAL INSURANCE:

Insurance Name | Address

Policy Holder's Name | Policy Holder's Social Sec # | Member Number | Group Number

EMERGENCY CONTACT INFORMATION:

Name _____ Address _____

Phone _____ Relationship _____

Is another member of your family a Dental House patient? ☐ Yes ☐ No

Name _____

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MEDICAL / DENTAL HISTORY:

Are you experiencing dental pain or discomfort? ..... YES NO

Are you in good general health? ..... YES NO

Do you smoke or use tobacco products? ..... YES NO

Women: Are you pregnant or suspect you might be? ..... YES NO

Has there been a change in your general health within the past year? ..... YES NO

Please explain: _____

Are you under the care of a physician? ..... YES NO

If so, what condition is being treated? _____

Physician's Name _____ Phone Number _____

Please check any of the following that apply:

- ☐ AIDS (AI)
- ☐ Alcoholism (AL)
- ☐ Anemia (AN)
- ☐ Angina (AG)
- ☐ Artificial Heart Valve (AV)
- ☐ Artificial Joints (AJ)
- ☐ Arthritis / Rheumatism (AR)
- ☐ Asthma (A)
- ☐ Birth Control (BC)
- ☐ Blood Pressure – High (BH)
- ☐ Blood Pressure – Low (BL)
- ☐ Blood Thinners (BT)
- ☐ Bruise Easily (BB)
- ☐ Cancer (CA)
- ☐ Chemotherapy / Radiation (CR)
- ☐ Congenital Heart Disease (CH)
- ☐ Deaf (DF)
- ☐ Diabetes (DB)
- ☐ Drug Dependency (DD)
- ☐ Eating Disorder (ED)
- ☐ Emphysema (EM)
- ☐ Epilepsy (EP)
- ☐ Fainting / Dizziness (FD)
- ☐ Fever Blisters / Cold Sores (FS)
- ☐ Gag Easily (GE)
- ☐ Glaucoma (GL)
- ☐ Headaches – Frequent (HF)
- ☐ Heart Attack (HA)
- ☐ Heart Murmur (HM)
- ☐ Hemophilia (HP)
- ☐ Hepatitis (H)
- ☐ Hereditary Dis. / Deformities (HD)
- ☐ HIV Positive (VP)
- ☐ Herpes (HR)
- ☐ Hives (HI)
- ☐ Hyper Activity (HY)
- ☐ Hypoglycemia (HG)
- ☐ Jaundice (JC)
- ☐ Kidney/Liver Disease (KL)
- ☐ Mitral Valve Prolapse (HV)
- ☐ Night Sweats (NS)
- ☐ Osteoporosis (OS)
- ☐ Paralysis (PL)
- ☐ Prolonged Bleeding (PB)
- ☐ Psychiatric Treatment (PT)
- ☐ Rheumatic Fever (RF)
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sickle Cell Disease (SD)
- ☐ Sinus Trouble (ST)
- ☐ Stroke (SK)
- ☐ Tuberculosis (TB)
- ☐ Tumors (TM)

Have you had any other serious illness? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

_____

DRUGS / MEDICATIONS:

Are you allergic to or have you had a bad reaction to:

- ☐ Aspirin (AA)
- ☐ Barbiturates (AB)
- ☐ Codeine (AC)
- ☐ Erythromycin (AE)
- ☐ Iodine (AD)
- ☐ Keflex (AK)
- ☐ Local Anesthetic (LA)
- ☐ Nitrous Oxide (NO)
- ☐ Narcotics (NA)
- ☐ Penicillin (AP)
- ☐ Sulfa (AS)
- ☐ Tetracycline (AT)
- ☐ Latex
- ☐ Other Allergies: _____

_____

Have you taken any medication in the last six months? ☐ Yes ☐ No

Please list: _____

Please list any medication(s) you are taking now: _____

Reason(s): _____

_____

_____

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NEW PATIENT GENERAL CONSENT

GENERAL CONSENT

Thank you for choosing **Dental House** for your dental care!

We are eager to work with you to help you achieve excellent oral health! While we pledge to maintain strict standards of safety in your clinical care, dental treatment, like treatment of any part of your body, carries some inherent risk. Your clinician will always weigh the risks versus rewards and discuss them with you, however, no clinical procedure is 100% risk-free. Treatment decisions will be made between you and your dentist after discussing the potential outcomes of your treatment plan. These risks are seldom great enough to offset the benefits of treatment but they should be considered when making treatment decisions.

Benefits of dental treatment can include relief from pain, increased ability to chew, and all the psychological and social benefits of a brighter, more pleasing smile. Still, there are some risks that almost all dental procedures carry:

1. Drug or chemical allergic reactions
2. Long-term numbness
3. Muscle or joint tenderness
4. Sensitivity in teeth of gums, infection, bleeding
5. Swallowing/inhaling small objects

Your safety and comfort are important to us! While no health care treatment can be totally predictable, it goes without saying that we will utilize all our knowledge and experience to make sure your treatment plan's outcome is the one you want.

Please feel free to ask your doctor questions when they arise. We are here for you!

_____ _____

Patient (or Parent/Guardian) Signature Date

_____

Print Name

_____ _____ _____

Relationship to Patient Date Witness

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HIPAA RECEIPT AFFIRMATION

AFFIRMATION

I affirm that I have received and read the Notice regarding my patient rights. I understand that if I want a copy of my patient rights, I may ask for it.

_____ _____

Patient (or Parent/Guardian) Signature Date

_____

Print Name

_____ _____

Relationship to Patient (if patient is a minor) Date

48-HOUR CANCELLATION POLICY (COVID-19)

Dear Patients:

Our mission is to provide you with the best patient experience possible. In order to keep providing our first-rate level of care and comfort, particularly in the era of COVID-19 and social distancing, our office requires your participation or we cannot continue our current clinical model.

We are currently restricted in the number of patients we can see daily so the predictability of each and every reserved chair is extremely important to the survival of our practice. Because of such difficult conditions, just **two** incidents of the following will unfortunately force our office to consider when or whether we can set another appointment:

- *Not showing up* for a chair time without any notice, or without two days prior notice
- *Canceling or rescheduling* a chair time with less than two days prior notice

We do not double- or triple-book like some other offices. This means if you cancel or do not show without giving our office time to rebook your time slot, your chair remains empty. Two treatments can equal roughly a half-day or more, which over time can threaten the survival of our office. If you are feeling unwell, please let us know and we will not count it against you.

We hope you work with us in this difficult time so that we may continue providing the best dental experience in town. If we work together, like all things in life, everybody wins.

_____ _____

Patient/Guardian Signature Date

_____

Please Print Patient Name