East County Family
Dental Center

## ***Patient Information (Confidential)***

Full Legal Name:

_____

Day time phone number: (_____) _____

Birthdate: _____/_____/_____ SSN Number: _____

Email Address: _____@_____

Mailing Address:

_____

City: _____State: _____ Zip Code:

_____

## ***Insurance Information***

Name of Company: _____

Subscribers Name: _____

Member Identification Number: _____

# Adult Health / Dental History 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.

Patient's Name: | SSN or PT ID: | Date of Birth:

Address: PO Box or Mailing Address | City | State | Zip Code

Occupation: | Height: | Weight:

Phone: ( ) Home ( ) Work | Emergency Contact | Sex: M☐ F☐ Non binary☐

Are you completing this form for another person? ☐ Yes ☐ No | If yes, name? | If yes, relationship?

Do you have any of the following diseases or problems: **(check DK if you don't know the answer to the question)**

| | Yes | No | DK |
|---|---|---|---|
| 1. Active Tuberculosis? | ☐ | ☐ | ☐ |
| 2. Persistent cough greater than a three-week duration? | ☐ | ☐ | ☐ |
| 3. Cough that produces blood? | ☐ | ☐ | ☐ |
| 4. Exposed to anyone with Tuberculosis? | ☐ | ☐ | ☐ |

**If you answer yes to any of the four items above, please STOP and return this form to the receptionist.**

**Please list the name and phone number of your physician:** Physician _____ Phone ___-___-____

## *Medical Information*

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

***Allergies - Are you allergic to or have you had a reaction to:***

| | Yes | No | DK | | Yes | No | DK | | Yes | No | DK |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Animals | ☐ | ☐ | ☐ | Food | ☐ | ☐ | ☐ | Local anesthetics | ☐ | ☐ | ☐ |
| Aspirin | ☐ | ☐ | ☐ | Hay fever/seasonal | ☐ | ☐ | ☐ | Penicillin or other antibiotics | ☐ | ☐ | ☐ |
| Barbiturates/sedative/sleeping pills | ☐ | ☐ | ☐ | Iodine | ☐ | ☐ | ☐ | Sulfa drugs | ☐ | ☐ | ☐ |
| Codeine or other narcotics | ☐ | ☐ | ☐ | Latex (rubber) | ☐ | ☐ | ☐ | Other: | ☐ | ☐ | ☐ |

*If Yes or other, please explain:* _____

**Medications:**

| | Yes | No | DK |
|---|---|---|---|
| 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 diet supplements: | ☐ | ☐ | ☐ |

**Health History:**

| | Yes | No | DK | | Yes | No | DK |
|---|---|---|---|---|---|---|---|
| *Do you wear contact lenses?* | ☐ | ☐ | ☐ | *Do you use controlled substances (drugs)?* | ☐ | ☐ | ☐ |
| **Joint Replacement.** Have you had an orthopedic total joint (hip knee, elbow, finger) replacement? If yes, Date: _____ Any complications? _____ | ☐ | ☐ | ☐ | Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? Circle one **VERY / SOMEWHAT / NOT INTERESTED** | ☐ | ☐ | ☐ |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease, Multiple Myeloma, or Cancer? | ☐ | ☐ | ☐ | Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____ | ☐ | ☐ | ☐ |

**Health History: (continued):**

| | Yes | No | DK |
|---|---|---|---|
| *Are you in good health?* | ☐ | ☐ | ☐ |
| Are you now under the care of a physician?<br>Physician Name:_____<br>Phone Number:_____<br>Address:_____ | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year?<br>If yes, what condition is being treated?<br>_____ | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?<br>*Date Treatment began:*_____ | ☐ | ☐ | ☐ |

| | 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?*<br>_____<br>_____<br>_____ | ☐ | ☐ | ☐ |
| Date of last physical exam:_____ | ☐ | ☐ | ☐ |
| **WOMEN ONLY Are you:** | | | |
| Pregnant?<br>Number of weeks?_____ | ☐ | ☐ | ☐ |
| Taking birth control or hormone replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

## Health History: *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 |
|---|---|---|---|
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date:_____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus | ☐ | ☐ | ☐ |
| Erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |

| | 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 | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/ persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting or Dizziness | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, specify:<br>_____ | | | |
| Sleep disorder | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| If yes, specify:<br>_____ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection:<br>_____ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches or migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted Disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |
| Difficulty Swallowing | ☐ | ☐ | ☐ |
| Diarrhea/Constipation /Blood in stool | ☐ | ☐ | ☐ |
| Vomiting /Nausea | ☐ | ☐ | ☐ |
| Difficulty Urinating | ☐ | ☐ | ☐ |
| Ringing in the Ears | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ |
| Skin Disease | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder ADHD) | ☐ | ☐ | ☐ |
| Autism Spectrum Disorder (ASD) | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Family History Problems?<br>_____<br>_____ | ☐ | ☐ | ☐ |
| Do you have any disease, condition, or problem not listed above that you think I should know about?<br>_____<br>_____ | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ | ☐ |
| Name of physician or dentist making recommendation:<br>_____<br>Phone : (_____)_____ _____ | | | |

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

How often do you brush your teeth? _____ How often do you floss? _____

How often do you visit the dentist? _____ Date of your last dental exam: _____

Name of former Dentist? _____ Date of last dental x-rays: _____

| **Dental History:** | Yes | No | DK | | Yes | No | DK |
|---|---|---|---|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ | Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any loose teeth? | ☐ | ☐ | ☐ | Do you suffer from bad breath? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ | Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Does food or floss catch between your teeth? | ☐ | ☐ | ☐ | Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ | Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ | Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ | Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ | Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ | Are you currently experiencing dental pain or discomfort | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ | On a scale of 1 -10 how would you rate your pain? | | | |
| If yes, how often? | | | | ☐☐☐☐☐☐☐☐☐☐ | | | |
| Circle one: **DAILY / WEEKLY / OCCASIONALLY** | | | | 1 2 3 4 5 6 7 8 9 10 | | | |

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.

Patient's Signature _____ Date _____

**For Completion by Dentist:**

Review of Systems: ( HEENT, GI, Resp, GU, MS, Endo, Skin, Neuro, Hemo)

Contraindications: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Signature of Dentist **Reviewed by:** _____ **Date:** _____

Medical History Review:

| | | | |
|---|---|---|---|
| 1 | Patient Signature: | | Date: |
| | **Reviewing Dentist Signature:** | | **Date:** |
| 2 | Patient Signature: | | Date: |
| | **Reviewing Dentist Signature:** | | **Date:** |
| 3 | Patient Signature: | | Date: |
| | **Reviewing Dentist Signature:** | | **Date:** |
| 4 | Patient Signature: | | Date: |
| | **Reviewing Dentist Signature:** | | **Date:** |

# ***General Dentistry Informed Consent***

**Patient name:** _____

**(PLEASE PRINT)**

**Dentistry and the individual Dentist:** I understand that Dentistry is not an exact science and that a reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care they render me.

**Initial:** _____

**Drugs and Medications:** I understand antibiotics and analgesics and other medication can lead to allergic reactions causing redness swelling of tissue, pain, itching, vomiting and anaphylactic shock (severe allergic reaction) I understand when using local anesthetics bruising can develop.

**Initial:** _____

**Changes in the treatment plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the tooth that were not discovered during examination. The most common being root canal therapy following restorative procedures such as fillings, inlays, onlays, crowns, veneers, and bridges. I understand that changes and additions maybe necessary and will be explained.

**Initial:** _____

**Oral Surgery (Tooth Removal):** I understand removing teeth does not always remove all the infection. With current infections treatment is necessary. I understand the risks involved in having teeth removed (paresthesia that can last for an indefinite period) and/or jaw fracture. I understand I may need further treatment by a specialist or even hospitalization if complications during or following treatment occur, that cost of which is my responsibility. Sinus communication can result from extractions of upper molars, extractions of lower molars can result in the tooth being pushed into a submandibular space. **Initial:** _____

**Crowns and Bridges, Inlay, Onlay, Veneers:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that

they are kept on until the permanent is delivered. I realize the final opportunity to make changes in my new crown, bridge (including shade, color, and size) will be before cementation. I understand that when a bridge is cemented it is important to use a floss threader to clean it. I understand that no Metal Crowns or amalgam filling material will not be used to restore my teeth.

**Initial:** _____

**Dentures (Complete or Partial):** I realize that full or Partial dentures are artificial teeth, constructed of plastic, metal or porcelain. Some problems may arise (including shape, fit size, or color) will be the teeth in wax and try in teeth visit. I understand that most dentures require relining in approximately 12 months after initial placement, for immediate 6 months. The cost for this procedure is not included in the initial denture fabrication fee.

**Initial:** _____

**Endodontic Treatment (Root Canals):** I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally objects are cemented in the tooth that may extent past the root. This does not necessarily affect the success of treatment. I also understand that occasionally additionally treatment will be needed after root canal treatment (Apicoectomy). Also, in some teeth the nerve canals become calcified because of long standing infection and we cannot completely fill and clean the canals. **Initial:** _____

**Periodontal Loss (Involving gums tissue and bone):** I understand that sever periodontal problems can lead to the loss of teeth. I understand it is important that follow through with my periodontal work including post-operative re-evaluation. I also understand that long standing gum and bone problems are chronic infections and can lead to stroke, heart disease, lung disease, diabetes, gastric ulcer, osteoporosis, and pre-term babies. **Initial:** _____

**Temporomandibular Joint (TMJ):** Problems can develop from any kind of dental procedures conducted for any length of time. It is my responsibility to alert the dentist when experiencing jaw soreness or pain. **Initial:** _____

**Signature:** _____ **Date:** _____

# ***HIPPA Compliance Patient Consent Form***

Our Notice of Privacy Practices provide information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your right under the law. You are certain by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment of health care operations. We are not required to agree with this restriction, however if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) Law allows for the use of the information for treatment, payment of healthcare options.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will be retroactive.

By Signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practices reserve the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of this information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at anytime and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical conditions with any member of your family? (Yes / No)
If yes, please name the members allowed:

_____

This Consent was signed by _____

(PLEASE PRINT YOUR NAME)

Signature: _____ Date: _____

# ***Aerosol Transmissible Diseases (ATD)***

In compliance with CCT title 8 Section 5199, dental facilities must pre-screen patients for (ATD). We use this form to pre-screen patients before any dental procedure is performed to determine whether the patient may present an (ATD) exposure risk.

Do you have any of the following:

- A history of Tuberculosis (TB)? (Yes/No)
- Symptoms of Tuberculosis? (Yes/No)
- Bloody sputum? (Yes/No)
- Night sweats? (Yes/No)

Do you have Flu or other Aerosol transmissible diseases, including Pertussis, Measles, Mumps, Rubella, Chicken pox or Meningitis? Yes or No

If yes, please explain: _____

Do you have any of the following, please circle Yes or No.

- Active fever? (Yes/No)
- Body aches? (Yes/No)
- Runny nose? (Yes/No)
- Sore throat? (Yes/No)
- Headache? (Yes/No)
- Nausea? (Yes/No)
- Vomiting or diarrhea? (Yes/No)
- Coughing spasms? (Yes/No)
- Skin rash or blisters? (Yes/No)
- Stiff neck or mental changes? (Yes/No)

# ***Chronic Respiratory Diseases***

Do you have any of the following? Please circle Yes or No.

- Asthma? (Yes/No)
- Bronchitis? (Yes/No)
- Emphysema (Yes/No)
- Dry cough from ACE inhibitors? (Yes/No)
- Upper airway cough syndrome "postnasal drip"? (Yes/No)
- Gastroesophageal reflux disease "GERD"? (Yes/No)
- Chronic obstructive pulmonary disease "COPD"? (Yes/No)

After reading through the questions, I declare that I have answered honestly to the best of my knowledge.

Signature: _____ Date: _____

- Is there anything we should no about that is not listed? (Yes/No)

If yes, please explain. _____

# East County Family Dental Center

Our Office Policy for no show, missed or Cancelled appointments without a 24-hour notice during business days Monday-Friday will be charged a $50.00 Cancellation fee.

Our time is valuable, thank you for your consideration.

Signature: x_____ Date: _____

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