Medical History

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physican's care now? ❍ Yes ❍ No If yes _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No If yes _____

Do you use tobacco? ❍ Yes ❍ No

Women: Are you . . .

❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic
❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics

Any Other Known Allergies? ❍ Yes ❍ No If yes _____

Do you use controlled substances? ❍ Yes ❍ No If yes _____

Do you have, or have you had, any of the following?

Hemophilia	❍Yes	❍No	Radiation Treatments	❍Yes	❍No	Alzheimer's Disease	❍Yes	❍No	Diabetes	❍Yes	❍No
Recent Weight Loss	❍Yes	❍No	Anaphylaxis	❍Yes	❍No	Renal Dialysis	❍Yes	❍No	Anemia	❍Yes	❍No
Herpes	❍Yes	❍No	Rheumatic Fever	❍Yes	❍No	Angina	❍Yes	❍No	Emphysema	❍Yes	❍No
High Blood Pressure	❍Yes	❍No	Rheumatism	❍Yes	❍No	Arthritis/Gout	❍Yes	❍No	Epilepsy or Seizures	❍Yes	❍No
High Cholesterol	❍Yes	❍No	Scarlet Fever	❍Yes	❍No	Artificial Heart Valve	❍Yes	❍No	Excessive Bleeding	❍Yes	❍No
Hives or Rash	❍Yes	❍No	Shingles	❍Yes	❍No	Artificial Joint	❍Yes	❍No	Hypoglycemia	❍Yes	❍No
Sickle Cell Disease	❍Yes	❍No	Asthma	❍Yes	❍No	Fainting Spells/Dizziness	❍Yes	❍No	Irregular Heartbeat	❍Yes	❍No
Sinus Trouble	❍Yes	❍No	Blood Disease	❍Yes	❍No	Frequent Cough	❍Yes	❍No	Kidney Problems	❍Yes	❍No
Spina Bifida	❍Yes	❍No	Blood Transfusion	❍Yes	❍No	Frequent Diarrhea	❍Yes	❍No	Leukemia	❍Yes	❍No
Stomach/Intestinal Disease	❍Yes	❍No	Breathing Problems	❍Yes	❍No	Frequent Headaches	❍Yes	❍No	Liver Disease	❍Yes	❍No
Stroke	❍Yes	❍No	Bruise Easily	❍Yes	❍No	Glaucoma	❍Yes	❍No	Low Blood Pressure	❍Yes	❍No
Swelling of Limbs	❍Yes	❍No	Cancer	❍Yes	❍No	Hay Fever	❍Yes	❍No	Lung Disease	❍Yes	❍No
Thyroid Disease	❍Yes	❍No	Chemotherapy	❍Yes	❍No	Heart Attack/Failure	❍Yes	❍No	Mitral Valve Prolapse	❍Yes	❍No
Tonsillitis	❍Yes	❍No	Chest Pains	❍Yes	❍No	Heart Murmur	❍Yes	❍No	Osteoporosis	❍Yes	❍No
Tuberculosis	❍Yes	❍No	Cold Sores/Fever Blisters	❍Yes	❍No	Ulcers	❍Yes	❍No	Pain in Jaw Joints	❍Yes	❍No
Congenital Heart Disorder	❍Yes	❍No	Parathyroid Disease	❍Yes	❍No	Behavior Disorder	❍Yes	❍No	Psychiatric Care	❍Yes	❍No
Venereal Disease	❍Yes	❍No	HIV positive	❍Yes	❍No	Organ Transplant	❍Yes	❍No	ADHD	❍Yes	❍No
Autism	❍Yes	❍No	Heart Disease/Condition	❍Yes	❍No	Hepatitis A B or C	❍Yes	❍No	Alcoholism	❍Yes	❍No
Multiple Sclerosis	❍Yes	❍No	Lupus	❍Yes	❍No	Dementia	❍Yes	❍No	Bacterial Endocarditis	❍Yes	❍No
Pacemaker	❍Yes	❍No	Jaundice	❍Yes	❍No				Splenectomy	❍Yes	❍No

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

Patient Information

(Confidential)

Name _____ Birth Date_____ SS#_____

Address_____ City_____ State_____Zip_____

Home Phone _____Cell Phone_____ Confirm appts by: call or text

Employer_____ Work Phone_____

Name of Previous Dentist_____ Date of Last Exam _____

If Minor, Father's Name_____Mother's Name_____

If Student, Name of School/College _____

Name of Spouse _____ SS#_____

Spouse's Employer_____ Spouse's Birth Date_____

Whom may we thank for referring you?_____

Responsible Party

Name_____ Birth Date_____SS#_____

Relationship to Patient _____ Phone _____

Address_____ City_____ State _____Zip_____

Employer_____

Insurance Information

Name of Insured_____ Birth Date _____

ID/SS# _____ Name of Employer _____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payments directly to DeWitt Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff at DeWitt Family Dentistry to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

x _____ Date_____

Signature of patient (or parent if a minor)

DeWitt Family Dentistry P.C.

923 6th Avenue
DeWitt, Iowa 52742

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers and confirm coverage.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Confirm appointments using voicemail, postcards, or letters.
- Disclose health information to a family member, friend, or caregiver to the extent necessary to help with your healthcare.

I acknowledge that I have read and/or received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature of Patient: _____
(or Personal Representative)

Date: _____

Please print your children's first and last names below:

_____

_____

_____

_____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____

_____ Individual refused to sign _____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement _____ Other (please specify)

_____

_____