**ADA** American Dental Association®

Today's Date: ______________________

# Patient Dental & Medical Health History Information

**To our patients:** Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

## PATIENT INFORMATION

Last Name: | First Name: | Middle Name:

Home Phone: | Cell Phone: | Work Phone:

Email Address:

Mailing Address: | City: | State: | Zip:

Date of Birth: / / | Gender:

Occupation:

Emergency Contact: Name: | Relationship: | Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: ______________________ Relationship: __________

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

## DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

**Please mark an "X" in the box ONLY if this applies to you.**

- Is it hard to open your mouth? ☐
- Does it hurt to chew, bite or swallow? ☐
- Do your gums bleed when you brush or floss your teeth? ☐
- Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
- Do you have, or have you ever had, any sores or growths in your mouth? ☐
- Do you clench or grind your teeth? ☐
- Does your jaw click, pop or hurt? ☐
- Do you have earaches or neck pains? ☐
- Does dental treatment make you nervous? ☐
- Have you ever experienced any of these sleep-related breathing disorders? ☐
  ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

- Have you ever had a serious injury to your head or mouth? ☐
  If yes, please describe what happened and when it happened: ______________________
- Have you ever had problems with dental treatment in the past? ☐
  If yes, please describe what happened: ______________________
- Have you ever had a reaction to, or problem with, dental anesthesia? ☐
  If yes, please describe what happened: ______________________
- Are you unhappy with your smile? ☐
  If yes, why? Please mark all that apply:
  ☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
  ☐ Other. Please describe: ______________________

## MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

**Please use an "X" to mark your answers to the following questions.** (Yes / No / ?)

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐

If yes, what medication are you taking? ______________________

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).

If yes, what medication are you taking? ______________________

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).

If yes, what medication are you taking? ______________________ How many years have you been taking it? __________

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? __________

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐

If yes, what substances? __________ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? __________

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements**? ☐ ☐ ☐

If yes, please list them here and include information about how much and how often you use each one. __________

Do you use **GLP-1 Glucagon-Like Peptide-1 medication**? ☐ ☐ ☐

**WOMEN ONLY:** Are you:

Taking **birth control pills**? ☐ ☐ ☐

**Pregnant**? If yes, number of weeks: __________ ☐ ☐ ☐

**Nursing**? If yes, number of weeks: __________ ☐ ☐ ☐

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## ALLERGIES Please use an "X" to mark your answers to the following questions.

**Are you allergic to or have you had an allergic reaction to:**

| | Yes | No | ? |
|---|---|---|---|
| Aspirin | ☐ | ☐ | ☐ |
| Barbiturates, sedatives or sleeping pills | ☐ | ☐ | ☐ |
| Codeine or other narcotics | ☐ | ☐ | ☐ |
| Hay fever/seasonal allergies | ☐ | ☐ | ☐ |
| Iodine | ☐ | ☐ | ☐ |
| Latex (rubber) | ☐ | ☐ | ☐ |
| Local anesthetics | ☐ | ☐ | ☐ |
| Metals | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ | ☐ |
| Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix) | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

Please describe any "Yes" answers and include information about your experience. ____________________

## MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

**Please use an "X" to mark your answers to the following questions.**

| | Yes | No | ? |
|---|---|---|---|
| Are you in good physical health? | ☐ | ☐ | ☐ |
| Are you currently being seen or treated by a physician? | ☐ | ☐ | ☐ |
| Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? | ☐ | ☐ | ☐ |
| Have you had a **serious illness, operation or been hospitalized** in the past 5 years? | ☐ | ☐ | ☐ |
| Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? | ☐ | ☐ | ☐ |
| Have you had a **heart valve replacement or heart surgery**? | ☐ | ☐ | ☐ |
| Have you had an **organ or bone marrow/stem cell transplant**? | ☐ | ☐ | ☐ |
| Have you traveled internationally within the last 30 days | ☐ | ☐ | ☐ |
| Have you had a fever (100.4°F or above) in the last 72 hours? | ☐ | ☐ | ☐ |

If you answered yes to any of the above, please explain: ____________________

## MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

**Do you have, or have you been diagnosed with, any of the following conditions?**

| | Yes | No | ? |
|---|---|---|---|
| **Heart (Cardiac) Health** | | | |
| Pacemaker/implanted defibrillator | ☐ | ☐ | ☐ |
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | ☐ | ☐ | ☐ |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur/rhythm disorder | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| **Breathing (Respiratory) Health** | | | |
| Asthma (COPD) | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| **Cancer** | ☐ | ☐ | ☐ |
| Type: ______ | | | |
| Date of diagnosis: ______ | | | |
| Chemotherapy: ______ | | | |
| Radiation treatment: ______ | | | |
| **Blood (Circulatory) Health** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: ______ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| High or low blood pressure | ☐ | ☐ | ☐ |
| **Brain (Neurological)/Mental Health** | | | |
| Anxiety | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| Post-traumatic stress disorder | ☐ | ☐ | ☐ |
| Traumatic brain injury or concussion | ☐ | ☐ | ☐ |
| **Autoimmune Disease** | | | |
| AIDS or HIV Infection | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ |
| **Digestive Health** | | | |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. reflux/persistent heartburn (GERD) | ☐ | ☐ | ☐ |
| Stomach ulcers | ☐ | ☐ | ☐ |
| **Eye (Vision) Health** | | | |
| Glaucoma | ☐ | ☐ | ☐ |
| **Other** | | | |
| Arthritis | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes (type I or II) | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Frequent infections | ☐ | ☐ | ☐ |
| Type of infection: ______ | | | |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Immune deficiency | ☐ | ☐ | ☐ |
| Kidney problems | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Sexually transmitted infection (STI) | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |

Do you have any disease, condition, or problem that's not listed here? If so, please explain. ____________________

## MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

**In the past 30 days, have you:**

| | Yes | No | ? |
|---|---|---|---|
| had pain or tightness in the chest? | ☐ | ☐ | ☐ |
| coughed up blood or had a cough that lasted longer than 3 weeks? | ☐ | ☐ | ☐ |
| been exposed to anyone with tuberculosis? | ☐ | ☐ | ☐ |
| had a rapid or irregular heart beat? | ☐ | ☐ | ☐ |
| found it hard to catch your breath? | ☐ | ☐ | ☐ |
| had a high fever (greater than 101.5°F) for no reason? | ☐ | ☐ | ☐ |
| noticed a change in your vision? | ☐ | ☐ | ☐ |
| fainted for no reason? | ☐ | ☐ | ☐ |
| experienced vomiting, diarrhea, chills, night sweats or bleeding? | ☐ | ☐ | ☐ |
| had migraines or severe headaches? | ☐ | ☐ | ☐ |
| **Over the past two weeks,** have you felt connected to the world around you? | ☐ | ☐ | ☐ |

**NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.**
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: ____________________ Date: __________

## FOR COMPLETION BY DENTIST

Comments: ____________________

**Office Use Only:** ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: ____________________ Date: __________

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# Capital City Dental: Consent for Services

It will be helpful for you to know how the business aspects of our office are handled. To help you receive the best care, we ask that you spend a few minutes learning about our office policies. Our office is opened to ages 3 and up for the practice of General Dentistry. When necessary, you will b referred to a specialist who will bill you directly. Our business and clinical hours are 8:00 am to 5:00 pm Tue – Thur. and Friday 8am to 3pm. For your convenience, we have Voice Mail to take your messages if we are unable to take your call.

**ALL APPOINTMENTS ARE REQUIRED TO BE CONFIRMED. As a courtesy, we attempt to contact you via electronic sms and/or e-mail fo confirmation of the scheduled appointments. However, should you not confirm your appointment by 2pm the day prior to your appointment th appointment will be vacated. If you cancel an appointment without a minimum of 24-hour notice, or you don't show for an appointment, a minimum fee of $50 will be accessed to your account. Three (3) such occurrences may result in your termination as a patient.**
**Late arrivals for a scheduled appointment are not always able to be seen by the provider due to courtesy to our other patients. A late arrival fe of $50 or a portion of the treatment fee may be assessed. Repeated late arrivals may result in your termination as a patient.**

**Initial**___________

**Patients with dental insurance (all patients with dental insurance, please read thoroughly):**

1) Please understand that all dental services furnished are charged directly to the patient and he/she is personally responsible for payment of all dental services. Insurance is billed as a courtesy to all our patients. Every attempt is made to determine the exact amount that your insurance will cover for any procedure however, the final responsibility for payment rests with the patient. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Your estimated portion is always due at the time that treatment is rendered.** I understand that the fees and ***estimate*** listed for dental care can only be valid for a period of three months from the date treatment was diagnosed.
2) Please understand that our number one concern is to treat you with the most advanced materials and services available to improve the outcom and longevity of a healthy smile. Dr. Horgan has set a standard of care used in our office through his years of education and experiences. **Our standards and material choices will not be dictated by an insurance company.** Every dental insurance company operates differently and some have exceptions and exclusions for materials or procedures. If materials or services are rendered that are beyond what an insurance company provides for, **you as the patient will be held financially liable for such services.** It is the responsibility of the patient to understand what their particular insurance plan coverage contains. We will happily provide insurance and patient portion estimates for all procedures advised if asked for. However, please understand these are estimates only and it is the patient's responsibility to accurately obtain plan coverage from their personal insurance plan. **We do not have the time or resources to be responsible to know exactly what each and ever insurance plan will cover in each instance. This responsibility belongs to you the patient and your insurance provider.** If you are concerned please ask that all work be pre-authorized through your insurance company to give you a better estimate if needed.
3) I assign directly to Capital City Dental, Dr. Horgan, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

**Payment in full is expected at the time of the service.** For crowns, dentures, partials, and prosthesis, your portion, not including estimated insurance payment, is due in full at the time impressions are taken. **Patient portions 60 days past due will be charged a finance fee of 18% per annum.** In case of unpaid balances, collection agencies and small claims courts are used. Additional fees up to 45% and /or court cost are added to the account balance This is easily avoided by communicating with the office if there is a problem.

To facilitate payment we accept Visa, Master Card, American Express and Cash. On approved credit, you may make financial arrangements through Care Credit. Applications are available at the front desk. Financial arrangement other than those stated above must be made prior to the appointment. Any patient balance over 60 days will be charged a monthly interest rate of 18% per annum. The policies are no reflection on your personal credit and we do appreciate your understanding and cooperation. Patient credit balances remaining on their account will if within 1 year be returned or over 1 year will be exchanged for future dental treatment. If a credit card was used to obtain the credit balance a charge of 10% will be assessed on the credit balanc prior to patient refund.

I have received or read a copy of this office's Notice of Privacy Practices. I also grant permission for Capital City Dental to discuss my dental treatmen or other aspects of my dental care with ________________________________.

In consideration for the professional service rendered to me by the Dentist, or at my request, I agree to pay the value of said services to the Dentist, or th assignee, at the time the services are rendered. I further agree that the reasonable value of services shall be billed unless objected to, by me in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver term or condition and I further agree to pay costs and reasonable fees if suit were instituted hereafter.

I grant my permission to you or your assignee, to text, telephone and/or e-mail me regarding dental related matters.

I have read the above conditions of treatment and agree to their content.

______________________________ Date: ________________ Relationship to Patient: ____________________

Signature of patient, parent or guardian