OCONEE VALLEY HEALTHCARE

REGISTRATION FORM

Today's Date ____/ _____ / _____ (Please Print) Account Number: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name

Street Address	City	State	ZIP Code

Mailing Address if different than Physical Address	City	State	ZIP Code

Home Phone ( )	Cell Phone ( )	Name of Employer	Work Phone ( )

Birth Date / /	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Social Security ____ - ___ - ____

Sexual orientation
- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Other _____
- ☐ I don't know
- ☐ Choose not to disclose

Gender
- ☐ Male
- ☐ Female
- ☐ Gender Queer
- ☐ Choose not to disclose
- ☐ Transgender Female/ Male-to-Female
- ☐ Transgender Male/ Female-to-Male
- ☐ Other _____

Email Address

ADDITIONAL PATIENT INFORMATION

Race
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other
☐ Black/African American ☐ White ☐ American Indian/Alaska Native

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Language Best Spoken ☐ English ☐ Spanish ☐ Other_____	Homeless ☐ Yes ☐ No	Public Housing Patient ☐ Yes ☐ No

Family Size ☐ _____ ☐ Choose not to disclose	Income ☐ $_____ ☐ Choose not to disclose	Veteran ☐ Yes ☐ No ☐ Choose not to disclose	Student Status ☐ FT ☐ PT ☐ Not a student	Agricultural Worker ☐ Yes ☐ No

RESPONSIBLE PARTY / PARENT / GUARDIAN

Responsible Party / Guardian / Parent	Relationship to Patient	Birth Date / /

Street Address	City	State	ZIP Code	Home Phone ( )

Employer	Employer Address	Employer Phone ( )

DENTAL INSURANCE INFORMATION

Is this patient covered by Dental Insurance? ☐ Yes ☐ No

Primary Insurance Name	Subscriber Name	Subscriber DOB	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Secondary Insurance Name	Subscriber Name	Subscriber DOB	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT (OTHER THAN PARENT, GUARDIAN, REPSONSIBLE PARTY)

Name of Local Friend or Relative	Relationship to Patient	Home Phone ( )	Cell Phone ( )
Name of Local Friend or Relative (not living at the same address)	Relationship to Patient	Home Phone ( )	Cell Phone ( )

CONTINUED ON BACK

OCONEE VALLEY HEALTHCARE

ADDITIONAL INFORMATION			
Do you have a preferred pharmacy? ☐ Yes ☐ No	Pharmacy Name	Pharmacy Location	Pharmacy Phone ( )
Medical Insurance Coverage: ☐ None/Uninsured ☐ Medicaid ☐ Medicare ☐ Both Medicaid & Medicare ☐ Other Public Insurance ☐ Private Insurance			
Chose Clinic Because / Referred to Clinic By (Please check one box): ☐ Dr. _____ ☐ Hospital _____ ☐ Family _____ ☐ Friend _____ ☐ Internet ☐ Phone Book ☐ Other _____			

_____**Initial** **CONSENT FOR TREATMENT:** I authorize Oconee Valley Healthcare and assistants they may designate to carry out diagnostic procedures, if needed, to better diagnose my condition and to administer treatments and medication as indicated. I understand that my condition may call for a consultation with another physician, dentist or specialist. If the necessity for consultation arises, I authorize Oconee Valley Healthcare to release medical information needed to improve the medical and dental treatment I receive. I may be treated by an Augusta University student under the direct supervision and responsibility of a licensed dentist. I understand my anonymous dental records may be used for education and training purposes.

_____**Initial** **ASSIGNMENT OF BENEFITS:** I authorize my insurance company to pay directly to Oconee Valley Healthcare the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments. If I receive the claim payment from my insurance company, I will forward the payment to Oconee Valley Healthcare within one week.

_____**Initial** **PAYMENT AGREEMENT:** Contact information, registration data and my health history are all complete and true to the best of my knowledge. I request Oconee Valley Healthcare to provide me and/or my family with medical and dental care. I acknowledge my responsibility to pay for services according to the policies established by Oconee Valley Healthcare.

_____**Initial** **NO SHOWS AND CANCELLATIONS:** I have received a copy of the No Show & Cancellations Policy and I understand I must keep my appointments or give 24 hours advance cancellation notice. If I violate the policy, I understand I will receive appointments for same day or next day only and receive treatment as time permits.

_____**Initial** **NOTICE OF PRIVACY PRACTICES:** I have received the Notice of Health Information Practices from Oconee Valley Healthcare. I have read and reviewed the notice. All of my questions were answered to my satisfaction.

_____**Initial** **DENTAL OFFICE POLICIES:** I have received the Dental Clinic Policies. I have had the opportunity to read, review and ask questions regarding the Dental Clinic Policies. I understand that violation of the office policies may result in my immediate removal from the premises or my dismissal as a patient.

I have been provided a copy of the "No Show & Cancellation Policy," "Notice of Privacy Practices" and "Dental Office Policies." I have had the opportunity to ask questions regarding the consent, agreements and policies outlined above.

Patient/Guarantor Signature _____ *Date* _____

Front Office Signature _____ *Date* _____

We are delighted to provide you and your family dental services at Oconee Valley Healthcare. At every visit, you will receive individualized attention for your specific medical and dental needs. You will have all of your questions and concerns addressed. You will receive care in a courteous and timely manner – we want this to be your best dental visit, *ever*! We require your compliance with our policies, because they enable us to provide our community with the highest quality of compassionate dental services.

This is a "SMOKE FREE" building. All smoking is prohibited. No alcohol or drug use is allowed on property, including the parking area. Law enforcement is available to escort any violator off the premises.

All co-pays, deductible amounts, and patient portions must be paid *at the time of service*.

If you are a Georgia Medicaid member, law requires that you present your current card *at each visit*.

If you have received a Reduced Fee/Slide Eligibility card, you must present your current card *at each visit*.

A government-issued photo ID and an in-person photo are required for accurate patient identification.

No Shows and Cancellations

This "No Show Policy" is also posted in the office; it follows a two-strikes rule. We must have your current contact information. We will call you 48 hours in advance of your appointment, and we must speak with you in-person to confirm your appointment time. If we have not heard from you 24 hours prior to your appointment, then it is cancelled. You may present as a "walk-in" for treatment as time permits. If you contact the office less than 24 hours before your appointment time to cancel or change it, then we do not have time to fill our schedule. If you are over 15 minutes late for your appointment time, your appointment is cancelled. If you "break" your appointment in any of these ways, you receive one strike. You will be informed if you receive a strike. After receiving two strikes, any future appointments are cancelled, and you may be given an appointment day. Present at 8:15AM for your appointment day and you will be treated on a "walk-in" basis as time permits. This policy guides the management of dental patients who do not keep appointments, or cancel with little notice, to maximize access for those patients responsible for keeping appointments.

Appointment Time is Doctor Time – Arrive Early

When confirming your appointment, we ask you to arrive 15 minutes prior to your appointment time. Your appointment time is your doctor time – please arrive early for check-in, insurance verification, and to be seated in the treatment room. If you arrive later than 15 minutes after your appointment time, you have two options: reschedule for another day, or wait to be treated on a "walk-in" basis as time allows.

Billing, Payment and Collections Policy

Payment is expected at the beginning of your appointment. You are informed of the approximate fees for your next visit in three instances: (1) when you contact the office to set up an appointment, (2) at the end of your previous appointment, and (3) when you are contacted to confirm your appointment. We accept payment in the form of cash, Visa, Mastercard, Discover or *local* check with a valid driver's license. If there are any changes in your treatment, we will collect or credit your account at check-out. All returned checks are subject to a $25 service charge. If you are unable to

pay your balance at the time of your appointment, we must reschedule your appointment. Statements are mailed monthly; please ensure your contact information is current for both phone and mail correspondence.

You must pay your balance before your next visit. Accounts over 90 days past due may be sent to a collections agency. You are responsible for collection fees, legal fees and additional costs associated with the delinquent account.

Dental Insurance Benefits

Oconee Valley Healthcare participates in Georgia Medicaid and PeachCare programs. Please present your current Medicaid or PeachCare card at check-in; law requires you bring your card to every appointment, or we must reschedule. We endeavor to participate with third-party insurers – please confirm "in-network" status with our front office and your insurance company before scheduling. We cannot guarantee insurance information given to us by insurance companies is correct or reflects current coverage. Your particular plan *may or may not* provide coverage for the services we advise are necessary for your health and well-being. If you are asked to return for a follow-up or next step appointment, you must do so *within one month*. This includes multistep procedures, such as crowns, dentures and bridges.

We accept assignment of your insurance benefits and file the claim with your insurance company as a courtesy to you. You are expected to pay your estimated portion at time of service. This is only an *ESTIMATE*. When your insurance company reimburses our claim, a balance may be due from you. Account statements are mailed monthly. We allow your insurance company 50 days to pay your claim. If your insurance does not pay, your account balance is your responsibility, and is subject to the above Billing, Payment and Collections Policy.

Reduced Fee Program

Oconee Valley Healthcare offers a reduced-fee program for patients who document their low-income status with the Oconee Valley Healthcare Eligibility Coordinator. Once approved, you must bring your eligibility card with you to receive reduced fees for that visit. Meet with the Coordinator first – fees for services already rendered cannot be reduced.

Parents and Legal Guardians

Minors (under age 18) must be accompanied by a parent or legal guardian, with appropriate documentation of parental status and legal custody, as needed. A minor may be treated individually if he/she provides documentation of legal emancipation. The parent or legal guardian of a minor is expected to remain on the premises for the duration of the visit, as additional treatment consent or health information may be required.

Patient Escort Policy

We must limit the number of people in the dental room to maintain safe operatory conditions for effective management of medical emergencies, and to deliver quality dental services consistently. Patients with a significant disability, or who require language interpretation, may be accompanied by one person. Parents of minor children are welcome in the operatory after the procedure is complete to discuss all findings and recommendations. Parents have the opportunity to enumerate their pre-treatment concerns on check-in paperwork. A "parent chair" is available in the treatment area hallway for an individual parent who wants to be in "hearing range" of a child patient; no parents are allowed in the treatment room, except as specifically indicated above.

NOTICE OF PRIVACY PRACTICES
Oconee Valley Healthcare
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students. and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders, pharmaceutical companies, Georgia Partnership for Caring, RSM workers, DFACS; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Teena Long Privacy Officer (706) 453- 1201 Ext 5119. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

No-Shows & Cancellations

Purpose: Guide management of dental patients who do not keep appointments, or cancel with little notice, to maximize access for those patients responsible for keeping appointments; provide on-time patients with timely, efficient dental treatment.

Two Strikes Policy

You receive *one strike* for each of the following reasons:

- Broken appointment (did not show for your appointment)
- Cancelled appointment with less than 24 hour notice
- Over 15 minutes late for your appointment time
- Failed to confirm your appointment time at least 24 hours in advance (see below)

We call to CONFIRM your appointment time 48 hours in advance

- You *must* call our office *and* speak with our front office to confirm your appointment *within 24 hours of your time*.
- If you don't confirm your appointment time 24 hours in advance, your appointment is cancelled – one strike.

We must have your current contact information to confirm your appointment, or it will be cancelled 24 hours in advance.

Once you receive two strikes, you are not allowed to schedule appointments for the next twelve (12) months. You may request to be on our quick call list for same-day appointments or present Friday afternoon at 2PM during our walk-in time. You may also request a standby date, where you arrive at 8AM (9AM Mondays), and are treated as time permits.

Patient Escort Policy

Purpose: Maintain safe operatory conditions to effectively manage medical emergencies, and to deliver quality dental services consistently.

- ❖ Competent patients are treated unescorted in the dental room. (Parent/guardian may escort children under age 4.)
- ❖ Patients with a significant disability, or who require language interpretation, may be accompanied by one person for consultion with dentist.
- ❖ No unattended children (under age 10) are allowed in the reception/waiting room.

Your child is more mature than you may expect

- It has been proven that children behave better and are more accepting of dental treatment in the absence of parents.
- In order to effectively render care to children of the practice, parents, guardians and siblings are expected to remain in the waiting area while the child receives dental services.
- The parent or legal guardian will be contacted in the event of treatment plan change, or if any other need arises to obtain the parent or guardian's consent.
- If a child is old enough to get on a school bus and attend kindergarten, then the child can handle a walk to our dental chair.

Parents of minor children are welcome in the operatory after the procedure is complete to discuss all findings and recommendations. Parents have the opportunity to enumerate their pre-treatment concerns on check-in paperwork.

I have read the above information regarding the Oconee Valley Healthcare Dental Patient Escort Policy and agree to the terms of this policy.

_____ _____

Signature Relationship to Patient

Health History Form

American Dental Association
www.ada.org

E-mail: Today's 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.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | 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**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

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

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	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?

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:

_____

_____

_____

_____

Medical Information

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

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
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?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

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

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
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	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent Infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

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.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments:_____