**PATIENT MEDICAL HISTORY**  Please print legibly

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Salutation | First Name | | | Last Name | | | M.I. |
| Home Phone ( ) | | Cell Phone ( ) | | | | Date of Birth | |
| Emergency Contact: | | | | |  | Gender | |
| Home Address | | | City/State/Zip | | | | |
| Referring Doctor | | | Occupation | | | | |
| E-mail Address | | | Social Security Number | | | | |

Height: \_\_\_\_\_FT\_\_\_\_\_IN Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_Lbs.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | UNSURE |
| Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain. |  |  |  |
| Has there been any change in your general health within the past year? If yes, please explain. |  |  |  |
| Are you under the care of a physician for a current problem? If yes, explain. |  |  |  |
| Have you been hospitalized within the past 5 years? Please specify. |  |  |  |
| Have you received therapy for alcoholism or drug addiction during the past 5 years? |  |  |  |
| Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications? |  |  |  |
| Is there any condition concerning your health that the doctor should be told? |  |  |  |
| Do you wish to speak to the doctor privately about anything? |  |  |  |
| Have you had abnormal bleeding with previous extractions, surgery, or trauma? |  |  |  |
| Have you ever required a blood transfusion? |  |  |  |
| Have you ever had surgery and/or radiation, chemotherapy for a tumor, growth, or other condition? |  |  |  |
| Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor. |  |  |  |
| Are you required to take antibiotics prior to dental treatment? |  |  |  |

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

* Sinus Trouble
* Thyroid problems
* Diabetes
* Stomach Ulcers, Colitis
* Hepatitis, Jaundice, Liver Disease
* Kidney problems
* Emphysema
* X-Ray treatment of Chemotherapy
* Bronchitis, Chronic Cough
* History of alcohol
* Psychiatric treatment
* Hay fever or sinus problems
* Problems with Immune System
* Difficult Breatheing or other lung trouble
* Chronic Fatigue or night sweats
* Chest pain, angina
* Arthritis or joint disease
* Cardiac pacemaker
* Fainting spells, Seizures
* Epilepsy
* Cancer
* Temporomandibular Joint Problem
* Low Blood Sugar
* Dialysis
* Irregular heart Beat
* Contagious Diseases
* Delay in healing
* Turberculosis
* Infectious Mononucleosis
* High Blood Pressure
* Heart Murmur
* Joint prosthesis (hip, knee, etc.)
* Rheumatic Fever
* Rheumatic Heart Disease
* Congenital Heart Disease
* Cardiovascular disease
* Heart attack, stroke or bypass
* Prosthetic heart valve
* Blood disorder
* Heart surgery
* Asthma
* Allergy to latex
* Low blood pressure

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have any disease, condition or problem not listed? Specify. | YES | NO | DON’T KNOW |

Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)? YES or NO

If Yes, how long were you on the medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­

If you are currently off the medication, how long ago did you discontinue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

Please continue:

**Women only:**

|  |  |
| --- | --- |
| Possibility of pregnancy: YES / NO | Nursing: YES / NO |
| Estimated delivery date: | Taking birth control pills: YES / NO |

**NOTE:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Would you like to authorize release of your health records (to include medical history, treatment notes, x-rays, account information and entire record) to anyone other than yourself? If so please indicate name, phone number and relationship below.

YES or NO If yes, please name individuals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like a copy of Notice of Privacy Practices YES NO

Are you taking any medication or drugs? If yes, please list them below.

**Medication Prescribed Dosage Frequency**

**Prescription Drug Monitoring Notification**

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances – like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxers and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to pre-scribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from Colorado State Department of Regulatory Agencies by calling 303-894-5957 or by visiting http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm .

**Financial Policy**

As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, and treatment narratives. We request that you pay your co-payment at the time of service. We accept cash, checks, Care Credit, Visa, MasterCard, American Express, and Discover.

Those with dental insurance:  We will estimate the portion your insurance is going to pay.  Since this varies for each individual, usually 20 - 75% of the cost of the procedure is required at the time of service.  We will bill your insurance for you.  *Insurance companies routinely indicate that coverage verification does not guarantee payment.  This means while we have done our best to estimate your out of pocket expense, when the insurance company actually processes the claim, the insurance payment may be less than expected.  In some cases the dental insurance may even pay more than estimated.*

If your insurance pays more than the estimated amount, a refund check from this office will be mailed within 1 month from the date payment is received in this office.  If your insurance pays less than the estimated amount, you will receive a statement from this office. NOTE:  *If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them.*

**Patient or Guardian Signature** \_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_