Health History Form

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: _____ Date of Birth: _____

Minor patients under the age of 18:

If you would like to authorize another adult to accompany your child to their dental appointment or to receive dental and health information, you will need to complete a "Minor Consent Form". Please ask the front desk receptionist for this form.

Do you have any of the following diseases or problems: **PLEASE CIRCLE YES OR NO**

Active Tuberculosis..... YES NO
Cough that produces blood..... YES NO
Been exposed to anyone with tuberculosis ..... YES NO

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

Dental Information (***PLEASE CIRCLE YES OR NO)***

Do your gums bleed when you brush or floss? ..... YES NO
Are your teeth sensitive to cold, hot, sweets or pressure? ..... YES NO
Is your mouth dry? ..... YES NO
Have you had any periodontal (gum) treatments? ..... YES NO
Are you currently experiencing dental pain or discomfort? ..... YES NO
Do you have clicking, popping or discomfort in the jaw? ..... YES NO
Do you have sores or ulcers in your mouth? ..... YES NO
Do you wear dentures or partials? ..... YES NO
Have you ever had a serious injury to your head or mouth? ..... YES NO
What is the reason for your dental visit today?

_____

Medical Information

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

Physician Name: _____ Phone Number: (___) _____
Date of last physical exam: _____
Are you in good health? ..... YES NO
Has there been any change in your general health within the past year? ..... YES NO
If yes, what condition is being treated? _____
Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... YES NO
If yes, what was the illness or problem? _____
Are you taking or have you recently taken any prescription or over the counter medicines? ..... YES NO
If so, please list all medicines, including vitamins, natural or herbal preparations and/or diet supplements?

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies – Are you allergic to or have you had a reaction to:

Local anesthetics..... YES NO
Barbituates, sedatives, or sleeping pills..... YES NO
Antibiotics ..... YES NO
If yes, specify:_____
Latex (rubber)..... YES NO
Iodine..... YES NO
Codeine or other narcotics..... YES NO
Aspirin..... YES NO
Sulfa drugs..... YES NO
Food..... YES NO
Metals..... YES NO
Other:_____

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

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ..... YES NO

Have you ever been 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 metastic cancer? ..... YES NO

Do you use controlled substances (drugs)? ..... YES NO

Do you use tobacco (smoking, snuff, chew)? ..... YES NO

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... YES NO

If yes, date: _____ Any complications? _____

WOMEN ONLY Are you:

Pregnant? ..... YES NO If yes, number of weeks: _____

Taking birth control pills or hormonal replacement? ..... YES NO

Nursing? ..... YES NO

Medical Conditions

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

Heart murmur	YES	NO	AIDS/HIV	YES	NO
Mitral valve prolapse	YES	NO	Sexually transmitted disease/herpes	YES	NO
Artificial heart valves	YES	NO	Anemia	YES	NO
Rheumatic fever	YES	NO	Hemophilia	YES	NO
Cardiovascular disease	YES	NO	Blood transfusion	YES	NO
Angina	YES	NO	If yes, date:		
Recurrent infections	YES	NO	Kidney disorder	YES	NO
Severe headaches/migraines	YES	NO	Autoimmune disease	YES	NO
Arteriosclerosis	YES	NO	Osteoporosis	YES	NO
Congestive heart failure	YES	NO	Systemic lupus	YES	NO
Coronary artery disease	YES	NO	Asthma	YES	NO
Damaged heart valves	YES	NO	Emphysema/COPD	YES	NO
Heart attack	YES	NO	Tuberculosis	YES	NO
Chest pain upon exertion	YES	NO	Arthritis	YES	NO
Stroke	YES	NO	Rheumatoid arthritis	YES	NO
Congenital heart defect	YES	NO	Diabetes	YES	NO
High blood pressure	YES	NO	Gastrointestinal disease	YES	NO
Low blood pressure	YES	NO	Reflux/Persistent heartburn	YES	NO
Rheumatic heart disease	YES	NO	Stomach ulcers	YES	NO
Pacemaker	YES	NO	Hepatitis/Liver disease	YES	NO
Cancer	YES	NO	Eating disorder	YES	NO
Radiation/Chemotherapy	YES	NO	Epilepsy/seizures	YES	NO
Neurological disorders	YES	NO	Mental illness	YES	NO
If yes, specify:			If yes, specify:		
Sinus trouble	YES	NO	ADHD	YES	NO
Thyroid disease	YES	NO	Glaucoma	YES	NO

Do you have any disease, condition, or problem not listed above? ..... YES NO

If yes, please explain: _____

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ..... YES NO

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

AUGUSTA REGIONAL DENTAL CLINIC

Patient Information

First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:____ /____ / ____ □Male □Female Social Security #:_____ - _____ - _____

Mailing Address:_____
(P.O. Box or Street Address) (City) (State) (Zip Code)

Home Phone #:_____ Cell Phone #:_____

Email Address:_____ □Single □Married □Separated □Divorced □Widowed □Minor

Patient Employer/School:_____ Occupation:_____

Employer/School Address: _____
(P.O. Box or Street Address) (City) (State) (Zip Code)

Employer/School Phone #:_____

Dental Insurance Information/Medicaid Information

Primary Insurance Company:_____

Name of Policy Holder:_____ Policy Holder Date of Birth: ____ /____ / ____

Policy Holder Social Security #:_____ - _____ - _____ Name of Employer:_____

Policy Holder ID #:_____ Group #:_____

Employer Address:_____
(P.O. Box or Street Address) (City) (State) (Zip Code)

Employer Phone #:_____ Relationship to patient:_____

Assignment and Release:
I certify that I, and/or my dependent(s), have insurance coverage with the above listed Insurance company and assign directly to the Augusta Regional Dental Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Augusta Regional Dental Clinic may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below.

_____ _____ _____
(Signature of Patient/Parent/Guardian) (Relationship to Patient) (Date)

Emergency Contact Information

Name:_____ Relationship to Patient:_____

Address:_____
(P.O. Box or Street Address) (City) (State) (Zip Code)

Home Phone #:_____ Cell Phone #:_____

The Augusta Regional Dental Clinic may contact the above named person in case of an emergency or in an effort to contact you in which we have failed to reach you by attempting all other resources you have provided.

_____ _____
(Signature of Patient/Parent/Guardian) (Date)

Patient Policies

Please read and initial that you understand each policy & sign bottom of form.

_____1. Patient Appointment Policies

Confirmation: The ARDC will attempt to confirm your appointment 2 business days prior to the appointment date. However, you must contact the clinic by 2pm the day prior to your appointment to confirm, failure to do so will result in the appointment being cancelled. If your phone is disconnected, unable to receive messages, or if we are unable to leave a message, the appointment will be cancelled. Please arrive for your scheduled appointments on time. If you arrive more than 5 minutes late, we may reschedule your appointment and you will lose your pre-paid deposit. You must give at least 24 hours notice if an appointment is being cancelled or rescheduled. This policy applies to appointments with off-site dentists or dental specialist.

Cancellations/No Shows: If you do not provide 24 hour notice to cancel or reschedule an appointment, we will be unable to reschedule you for six months or longer due to the volume of future patient appointments and you will lose your pre-paid deposit. Two No-Shows within a 12 month period means your clinic privileges are suspended indefinitely and you will lose your pre-paid deposit. One missed appointment with off-site dentists or dental specialist will result in being suspended indefinitely and you will lose your pre-paid deposit.

_____ 2. Treatment Plan Policy

If patient does not agree with the treatment plan, and their non-compliance jeopardizes the ARDC's ability to deliver an acceptable standard of care, or the patient insists upon a treatment that is not feasible at the clinic, patient will be required to seek care in private practice, or be dismissed from the clinic based on the individual situation.

_____3. Conduct Policy

The Dental Clinic is here to provide you and your children with the best care possible. Be respectful and cooperative to ARDC staff members as well as other ARDC patients; rude behavior or profane language will not be tolerated. Any patient thought to be intoxicated or chemically impaired at anytime, will be denied services or treatment and faces possible dismissal from the clinic. Failure to abide by these responsibilities will result in denial of services at the ARDC. The ARDC reserves the right to determine whether a patient shall or shall not receive services at our Clinic. If you have a complaint or concern about the service you have received from the dentists or any of the staff working in this practice, please let us know. Our complaints system adheres to state criteria.
*__**When adults are being treated, their children may not accompany them into the dental operatory. The dental department cannot provide child care while a parent is being treated.**__

_____4. Contact Information Policy

It is your responsibility to keep your contact information updated with the clinic. The clinic will make every attempt to contact you in reference to your appointments & dental treatment.

_____5. Payment Policy

Advance payment is required before each dental visit and must be cash, money order or Visa/MasterCard/Discover/American Express. **NO CHECKS ACCEPTED.** This policy does not apply to children with Medicaid coverage.

_____6. Narcotic Prescription Monitoring System Policy

Augusta Regional Dental Clinic participates in the **Virginia Prescription Monitoring System.**

I have read and understand the above Augusta Regional Dental Clinic policies.

_____ _____

Patient or Parent/Guardian Signature Date

Minor Consent Form

Office Policy

For all NEW patients under the age of 18, our office requires that the parent/legal guardian bring the child to their first dental appointment. Parent/legal guardian must give consent for ALL dental treatment. The parent/legal guardian granting consent must be legally authorized to do so. Minor patients who present to their first dental appointment without a parent/legal guardian present will not be seen.

Every 12 months, our office requires an update of patient's paperwork. The parent/legal guardian must be present at this appointment to update all paperwork. If an unaccompanied minor presents to this appointment without a parent/legal guardian, the child will not be seen.

Authorization

I have the legal right to preauthorize Augusta Regional Dental Clinic and its personnel to deliver dental treatment and services to my child. Dental care may include, but not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays, sealants, root canal treatment, nitrous oxide, restorative (fillings) procedures, crowns, extractions and any other treatment plan discussed and agreed upon by the parents/legal guardian. In the event of an emergency, I authorize emergent services, including the aid of 911/EMS.

I _____ (print parent/legal guardian name) request and authorize the Augusta Regional Dental Clinic and its personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

Child's Name: _____ DOB: _____

Parental Contact Information For Any Questions

Parent/Legal Guardian's Name: _____

Contact phone: (cell/home)_____ (work)_____

I hereby authorize _____ to bring my child to his/her appointments if I am unable to attend. I understand that medical/dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form are valid for 12 months or when a minor becomes the age of 18. Minor patients who present for an appointment within the 12 month period and are not accompanied by a person who was granted permission from parent/legal guardian, will not be seen.

Parent/Legal Guardian signature: _____

Relationship to patient: _____ Date: _____