

MEDICAL HISTORY / HIPAA CONSENT

Patient Name: _____

Please list your **Primary Care Physician's** information in case of emergency. Feel free to use our phonebook.

Doctor's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you been under the care of a medical doctor for anything unusual during the past two years? Yes No

If yes, for what? _____

Are you taking any medications or drugs currently, including regular doses or aspirin or over-the-counter herbal medications? Yes No

If yes, please list name and dosage (use back of page if necessary):

Are you aware of having an allergic reaction to any medication or substances? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past 5 years? Yes No

Indicate which of the following you have had or have at present

Circle any that apply to you

Heart Disease	Y N	Diabetes	Y N	Hepatitis A B C (circle)	Y N
Thyroid Problems	Y N	Chest pains	Y N	Venereal Disease	Y N
Glaucoma	Y N	Ulcers	Y N	A.I.D.S.	Y N
Contact Lenses	Y N	Chronic Cough	Y N	H.I.V. Positive	Y N
Cancer	Y N	Emphysema	Y N	Cold sores/fever blisters	Y N
Chemotherapy	Y N	Tuberculosis	Y N	Blood Transfusion	Y N
Latex Allergy	Y N	Hay Fever	Y N	Hemophilia	Y N
Sinus Troubles	Y N	Allergies/Hives	Y N	Sickle Cell Disease	Y N
Heart Murmur	Y N	Asthma	Y N	Bruise Easily	Y N
High Blood Pressure	Y N	Liver Disease	Y N	Nervous/Anxious	Y N
Mitral Valve Prolapse	Y N	Kidney Trouble	Y N	Cortisone Medicine	Y N
Artificial Heart Valve	Y N	Artificial Joints	Y N	Stroke	Y N
Swollen Ankles	Y N	Psychiatric Care	Y N	Neurological Disorders	Y N
Heart Pacemaker	Y N	Yellow Jaundice	Y N	Epilepsy or Seizures	Y N
Rheumatic Fever	Y N	Radiation Therapy	Y N	Fainting/Dizzy Spells	Y N
Arthritis/Rheumatism	Y N				

Do you have or have you had any disease, condition, or problem not listed? _____

Women: Are you pregnant _____ Nursing _____ Taking Birth Control Pills _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and will notify the dentist of any changes in my health or medication. Furthermore, in accordance with HIPAA Privacy Policy, I hereby give consent to Dr. Hecklin and all other dental care providers used for referring to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

Cancellation fees may be charged for missed appointments if appropriate notice is not given.

Patient/Guardian Signature _____ Date _____

Please review **ANNUALLY**, revise if any changes in your health history have occurred, and sign below.

Patient/Guardian Signature _____ Date _____

Patient/Guardian Signature _____ Date _____

Patient/Guardian Signature _____ Date _____

Patient/Guardian Signature _____ Date _____

DENTAL HISTORY

*Welcome! Please complete the following dental and medical history forms
so that we may provide you with the best possible care.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

Previous Dentist's Name: _____

Address: _____

Telephone: _____

How often do you have dental examinations? _____

Do you brush and floss your teeth daily? Yes No

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters,
or any oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth
loss? Yes No

Have you noticed any loose teeth or change in your
bite? Yes No

Do foods tend to get caught between your teeth?
If yes, where? _____ Yes No

Do you:

Clench/grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use any other tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Teeth ground? Yes No

Bite adjusted? Yes No

Bite plate or mouth guard? Yes No

Serious injury to mouth or head? Yes No

If so, please describe _____

Have you experienced:

Clicking or popping jaw? Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty opening/closing mouth? Yes No

Headaches, neck aches, shoulder
aches?

Sore muscles (neck or shoulders)? Yes No

Are you satisfied with your teeth's
appearance? Yes No

Do you feel nervous about having
dental treatment? Yes No

Have you had an upsetting dental experience? If yes, please describe: _____

Is there anything else about having dental treatments that you would like for us to know? If yes, please describe: _____