Patient Medical and Dental History

Personal Information

Name____Date________
(Last) (First) (Middle)

Address____County_________

City_____________________State_______________Zip_____________

Day Phone________ Evening Phone_____________Cell Phone____________

Birth Date___________Age_______Occupation______________Sex M or F

Social Security Number________________ Referred By________________

Responsible Party_____________Relationship_________Phone_________

Medical Doctors Name_________________Address/phone______________

Emergency Notification__________Phone_______ Relationship_________

Insurance Information

Dental Insurance Name______________________________________

Insurance ID Number____

Insurance Company phone number_____________________

Policy Holders Name ____________________Birthdate_______________

Other Information

Date of last dental visit_____________________

Reason for this visit_______________________

Have you ever had any of the following?

	Yes	No	Unsure
AIDS/HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Artificial Joints	☐	☐	☐
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Dizziness	☐	☐	☐
Epilepsy	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Fainting	☐	☐	☐
Glaucoma	☐	☐	☐
Growths	☐	☐	☐
Hay Fever	☐	☐	☐
Head Injuries	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Murmur	☐	☐	☐
Hepatitis	☐	☐	☐
High Blood Pressure	☐	☐	☐
Jaundice	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Mental Disorders	☐	☐	☐
Nervous Disorders	☐	☐	☐
Pacemaker	☐	☐	☐
Radiation Treatment	☐	☐	☐
	Yes	No	Unsure
Respiratory Problems	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Sinus Problems	☐	☐	☐
Stomach Problems	☐	☐	☐
Stroke	☐	☐	☐

Thyroid Disease ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Tumors ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Venereal Disease ☐ ☐ ☐
Codeine Allergy ☐ ☐ ☐
Penicillin Allergy ☐ ☐ ☐
Any other Allergies ☐ ☐ ☐
(metals, latex, or any other drugs, foods, or medications.)
Congenital Heart Disease ☐ ☐ ☐
Chest Pain ☐ ☐ ☐
Cold Sores ☐ ☐ ☐
Sexually Transmitted Disease(syphilis, gonorrhea, herpes, etc)
☐ ☐ ☐
Complications after Dental treatment
☐ ☐ ☐
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ ☐ ☐
Other____

Do you presently, or have you ever…

Yes No Unsure
Used Tobacco ☐ ☐ ☐
If yes, what type,how much, and for how long?____________________
Used Alcoholic Beverages
☐ ☐ ☐
Used Recreational or Street drugs
☐ ☐ ☐
Taken Fosamax or any Medication for osteoporosis
☐ ☐ ☐
Taken Phen-fen ☐ ☐ ☐

Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? If so, please list:

____

____

Women

	Yes	No	Unsure
Are you Pregnant now?	☐	☐	☐

If yes, due date________________________

Are you currently using a prescription – type contraceptive?

	Yes	No	Unsure
	☐	☐	☐

All health history answers have been answered and are current.

Signature:_____________________

Signature (Reviewing Doctor):_______________________

FourPoints Health Dental

Consent Form

I authorize any FourPoints Health provider and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangements and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatment.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen or Bisphosphonate osteoporosis medication (such as Fosamax, Boniva, Actonel, etc.).

I have been informed about what the sliding scale is, and whether I qualify or not. I understand that I need to provide the required documentation to maintain eligibility. I understand the procedures that qualify for the nominal fee, and that I am able to take advantage of non-covered procedures at a discounted rate.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Signature ________________________________ Date:_____________

Witness Signature________________________________ Date:_____________