



Patient's Name: \_\_\_\_\_

## DENTAL/MEDICAL HISTORY

Are you under a physician's care? What for? \_\_\_\_\_ Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_ Women: Are you pregnant? Y N  
Are you nursing? Y N Oral Contraceptives? Y N

Are you on a special diet? Y N Do you use tobacco? How much per day/week? \_\_\_\_\_ Do you use controlled substances? Y N

Do you drink alcohol? How much per day/week? \_\_\_\_\_ Have you ever taken Phen-Fen or Redux? Y N Have you had a serious neck injury? Y N

Do you have difficulty opening your mouth? Y N Do you clench or grind your teeth? Y N

Have you had difficulty with dental extractions, prolonged bleeding post-operatively in the past? Y N

Have you ever been advised by a physician to take a pre-medication before any dental appointments? Y N

Would you like to discuss cosmetic smile enhancement? Y N

Please circle items below if you have or have had any of the following:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B OR C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy/Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives/Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pace Maker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

Other: \_\_\_\_\_

Are you allergic or have you reacted adversely to any of the following medications:

Aspirin	Codeine	Sedatives	Local Anesthetics
Iodine	Penicillin	Sulfa Drugs	Erythromycin
Tetracycline	Any Metals (Nickel, Mercury)	Barbiturates	Latex Rubber

Other: \_\_\_\_\_

Have you ever taken any of the following medications or any other Bisphosphonates?:

Actonel	Aredia	Boniva	Fosamax
Zometa	Reclast	Herbal Supplementments	

**Consent:**

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

{Ginger Creek Dental}

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

## **\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

## **Authorization to Release Information**

**Purpose:** This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
Relationship

### **For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
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