# Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

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: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

*Your Name* *Relationship*

**Do you have any of the following diseases or problems:** *(Check DK if you Don't Know the answer to the question)*

| | Yes | No | DK |
|---|---|---|---|
| Active Tuberculosis | ☐ | ☐ | ☐ |
| Persistent cough greater than a 3 week duration | ☐ | ☐ | ☐ |
| Cough that produces blood | ☐ | ☐ | ☐ |
| Been exposed to anyone with tuberculosis | ☐ | ☐ | ☐ |

***If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.***

## Dental Information *Please mark (X) your responses to the following questions.*

| | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ |
| If yes, how often? (*Check one:*) DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐ | | | |
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

| | Yes | No | DK |
|---|---|---|---|
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |

If yes, what condition is being treated?

Date of last physical exam:

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |

If yes, what was the illness or problem?

| | Yes | No | DK |
|---|---|---|---|
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

*(Check DK if you Don't Know the answer to the question)*

| | Yes | No | DK |
|---|---|---|---|
| Do you wear contact lenses? | ☐ | ☐ | ☐ |
| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ | ☐ |
| Date: _____ If yes, have you had any complications? _____ | | | |
| Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ | ☐ |
| Date Treatment began: _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| Do you use controlled substances (drugs)? | ☐ | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED | ☐ | ☐ | ☐ |
| Do you drink alcoholic beverages? | ☐ | ☐ | ☐ |
| If yes, how much alcohol did you drink in the last 24 hours? _____ | | | |
| If yes, how much do you typically drink i n a week? _____ | | | |
| **WOMEN ONLY** Are you: | | | |
| Pregnant? | ☐ | ☐ | ☐ |
| Number of weeks: _____ | | | |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

**Allergies.** Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

| | Yes | No | DK |
|---|---|---|---|
| Local anesthetics _____ | ☐ | ☐ | ☐ |
| Aspirin _____ | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics _____ | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills _____ | ☐ | ☐ | ☐ |
| Sulfa drugs _____ | ☐ | ☐ | ☐ |
| Codeine or other narcotics _____ | ☐ | ☐ | ☐ |
| Metals _____ | ☐ | ☐ | ☐ |
| Latex (rubber) _____ | ☐ | ☐ | ☐ |
| Iodine _____ | ☐ | ☐ | ☐ |
| Hay fever/seasonal _____ | ☐ | ☐ | ☐ |
| Animals _____ | ☐ | ☐ | ☐ |
| Food _____ | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ |

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

| | Yes | No | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | | | |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

| | Yes | No | DK |
|---|---|---|---|
| Cardiovascular disease | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Other congenital heart defects | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion If yes, date: _____ | ☐ | ☐ | ☐ |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders If yes, specify: _____ | ☐ | ☐ | ☐ |
| Sleep disorder | ☐ | ☐ | ☐ |
| Do you snore? | ☐ | ☐ | ☐ |
| Mental health disorders Specify: _____ | ☐ | ☐ | ☐ |
| Recurrent Infections Type of infection: _____ | ☐ | ☐ | ☐ |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ | ☐ |

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

| | Yes | No | DK |
|---|---|---|---|
| Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain: | ☐ | ☐ | ☐ |

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
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:

Signature of Dentist: Date:

**FOR COMPLETION BY DENTIST**

Comments:


# Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in the patients care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental serviced, or any dental service performed without prior financial arrangements, must be paid for in cash at the time of services performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms to assist in making collections from insurance companies and will credit such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid, in full or partially, by an insurance company.

For dental procedures in excess of $500, at the discretion of Deukmedjian Dentistry Inc, a deposit may be requested.

A service charge of 1.5% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are planned and satisfied.

- I understand that the fee estimate listed for this dental care can only be maintained for six months from the date of the patient's examination.
- In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you, or your assigns, to telephone me at home or my work to discuss matters related to this form.
- I have read the above conditions of treatment and agree to their consent.

Signature _____ Date _____

# CONSENT FOR TREATMENT

I hereby grant authority to the dentist in charge of the care of the patient who appears on this and the Health History form, to administer any treatment; or to administer such anesthetics, analgesics, sedatives, Nitrous Oxide sedation or intravenous sedation; and to perform such operations as they may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have been informed of all possible complications of the procedures, anesthetics, and/or drugs.

Signature _____ Date _____

*Authorization must be signed by the patient or Guardian. In the case of a minor or when the patient is physically or mentally incompetent.

Relationship to patient: _____


# ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this Acknowledgement

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

_____
Signature

_____
Date

_____

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
- ☐ Communication barriers prevented obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____


# PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

## PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect November 5th, 2016 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you make revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, or with payment for your healthcare; but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, radiographs, or other similar forms of health information.

**Marketing Health Related Services:** We will not use your health information for marketing communications without your written consent.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.


# CANCELLATION POLICY

**We strive to maintain high standards and spend and allot plenty of time for each patient. A last minute cancellation can significantly impact the office. As such, there is a cancellation policy in place as follows:**

We ask that you please give our office at least 24 hours notice, excluding weekends, in the event that you need to reschedule your appointment. This allows for our office to have the best chance to fill that time. If you miss an appointment without contacting the office, or do not give more than 24 hours notice, a fee of $50.00 will be charged. Depending on how often this happens, no further appointments may be made without first paying the accumulated fees, and at the discretion of the office, a deposit may be necessary for further appointments. If a patient incurs at least three cancellation fees, they may, unfortunately, be dismissed from the office.

If you have any questions regarding this policy, please feel free to speak with Dr Deukmedjian.

I have read and understand the Appointment Cancellation Policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Name _____

Signature _____ Date _____

# SECURITY CAMERA NOTICE

To protect the office and everyone in it, there are security cameras in each operatory and one viewing the hallway. The audio is off to protect HIPAA information.

I, _____ have been informed of the security camera presence and location.

Signature _____ Date _____