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

Today's Date: ____________________

# Patient Dental & Medical Health History Information

**To our patients:** Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

## PATIENT INFORMATION

Last Name: First Name: Middle Name:

Home Phone: Cell Phone: Work Phone:

Email Address:

Mailing Address: City: State: Zip:

Date of Birth: / / Gender:

Occupation:

Emergency Contact: Name: Relationship: Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: ____________________ Relationship: __________

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

## DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

**Please mark an "X" in the box ONLY if this applies to you.**

- Is it hard to open your mouth? ☐
- Does it hurt to chew, bite or swallow? ☐
- Do your gums bleed when you brush or floss your teeth? ☐
- Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
- Do you have, or have you ever had, any sores or growths in your mouth? ☐
- Do you clench or grind your teeth? ☐
- Does your jaw click, pop or hurt? ☐
- Do you have earaches or neck pains? ☐
- Does dental treatment make you nervous? ☐
- Have you ever experienced any of these sleep-related breathing disorders? ☐
  ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

- Have you ever had a serious injury to your head or mouth? ☐
  If yes, please describe what happened and when it happened: ____________________
- Have you ever had problems with dental treatment in the past? ☐
  If yes, please describe what happened: ____________________
- Have you ever had a reaction to, or problem with, dental anesthesia? ☐
  If yes, please describe what happened: ____________________
- Are you unhappy with your smile?. ☐
  If yes, why? Please mark all that apply:
  ☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
  ☐ Other. Please describe: ____________________

## MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

**Please use an "X" to mark your answers to the following questions.** Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐

If yes, what medication are you taking? ____________________

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).

If yes, what medication are you taking? ____________________

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).

If yes, what medication are you taking? ____________________ How many years have you been taking it? __________

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? __________

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐

If yes, what substances? ____________ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? ____________________

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐

If yes, please list them here and include information about how much and how often you use each one. ____________________

**WOMEN ONLY:** Are you:

Taking **birth control pills**? ☐ ☐ ☐

**Pregnant**? If yes, number of weeks: __________ ☐ ☐ ☐

**Nursing**? If yes, number of weeks: __________ ☐ ☐ ☐

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## ALLERGIES
**Please use an "X" to mark your answers to the following questions.**

**Are you allergic to or have you had an allergic reaction to:**

| | Yes | No | ? |
|---|---|---|---|
| Aspirin | ☐ | ☐ | ☐ |
| Barbiturates, sedatives or sleeping pills | ☐ | ☐ | ☐ |
| Codeine or other narcotics | ☐ | ☐ | ☐ |
| Hay fever/seasonal allergies | ☐ | ☐ | ☐ |
| Iodine | ☐ | ☐ | ☐ |
| Latex (rubber) | ☐ | ☐ | ☐ |
| Local anesthetics | ☐ | ☐ | ☐ |
| Metals | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ | ☐ |
| Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix) | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

Please describe any "Yes" answers and include information about your experience. ______________________

## MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

**Please use an "X" to mark your answers to the following questions.**

| | Yes | No | ? |
|---|---|---|---|
| Are you in good physical health? | ☐ | ☐ | ☐ |
| Are you currently being seen or treated by a physician? | ☐ | ☐ | ☐ |
| Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? | ☐ | ☐ | ☐ |
| Have you had a **serious illness, operation or been hospitalized** in the past 5 years? | ☐ | ☐ | ☐ |
| Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? | ☐ | ☐ | ☐ |
| Have you had a **heart valve replacement or heart surgery?** | ☐ | ☐ | ☐ |
| Have you had an **organ or bone marrow/stem cell transplant?** | ☐ | ☐ | ☐ |
| Have you traveled internationally within the last 30 days | ☐ | ☐ | ☐ |
| Have you had a fever (100.4°F or above) in the last 72 hours? | ☐ | ☐ | ☐ |

If you answered yes to any of the above, please explain: ______________________

## MEDICAL HISTORY SPECIFIC
**Please use an "X" to mark your answers to the following questions.**

**Do you have, or have you been diagnosed with, any of the following conditions?**

| | Yes | No | ? |
|---|---|---|---|
| **Heart (Cardiac) Health** | | | |
| Pacemaker/implanted defibrillator | ☐ | ☐ | ☐ |
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | ☐ | ☐ | ☐ |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur/rhythm disorder | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| **Breathing (Respiratory) Health** | | | |
| Asthma (COPD) | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| **Cancer** | ☐ | ☐ | ☐ |
| Type: ______ | | | |
| Date of diagnosis: ______ | | | |
| Chemotherapy: ______ | | | |
| Radiation treatment: ______ | | | |
| **Blood (Circulatory) Health** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: ______ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| High or low blood pressure | ☐ | ☐ | ☐ |
| **Brain (Neurological)/Mental Health** | | | |
| Anxiety | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| Post-traumatic stress disorder | ☐ | ☐ | ☐ |
| Traumatic brain injury or concussion | ☐ | ☐ | ☐ |
| **Autoimmune Disease** | | | |
| AIDS or HIV Infection | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ |
| **Digestive Health** | | | |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. reflux/persistent heartburn (GERD) | ☐ | ☐ | ☐ |
| Stomach ulcers | ☐ | ☐ | ☐ |
| **Eye (Vision) Health** | | | |
| Glaucoma | ☐ | ☐ | ☐ |
| **Other** | | | |
| Arthritis | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes (type I or II) | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Frequent infections | ☐ | ☐ | ☐ |
| Type of infection: ______ | | | |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Immune deficiency | ☐ | ☐ | ☐ |
| Kidney problems | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Sexually transmitted infection (STI) | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |

Do you have any disease, condition, or problem that's not listed here? If so, please explain. ______________________

## MEDICAL SYMPTOMS/GENERAL
**Please use an "X" to mark your answers to the following questions.**

**In the past 30 days, have you:**

| | Yes | No | ? |
|---|---|---|---|
| had pain or tightness in the chest? | ☐ | ☐ | ☐ |
| coughed up blood or had a cough that lasted longer than 3 weeks? | ☐ | ☐ | ☐ |
| been exposed to anyone with tuberculosis? | ☐ | ☐ | ☐ |
| had a rapid or irregular heart beat? | ☐ | ☐ | ☐ |
| found it hard to catch your breath? | ☐ | ☐ | ☐ |
| had a high fever (greater than 101.5°F) for no reason? | ☐ | ☐ | ☐ |
| noticed a change in your vision? | ☐ | ☐ | ☐ |
| fainted for no reason? | ☐ | ☐ | ☐ |
| experienced vomiting, diarrhea, chills, night sweats or bleeding? | ☐ | ☐ | ☐ |
| had migraines or severe headaches? | ☐ | ☐ | ☐ |

**NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.**
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: ______________________ Date: ______________

## FOR COMPLETION BY DENTIST

Comments: ______________________

**Office Use Only:** ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: ______________________ Date: ______________

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## NOTICE OF 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. State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This notice takes effect on January 1, 2018 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our privacy notice at any time by contacting our front desk.

## TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone of our staff is required to sign a confidentiality statement.
**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.
**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition, or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.
**Health care operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our dental records staff, outside health or management reviewers and individuals performing similar activities.
**Required by law:** We may use or disclose your health information when required to do so by law, requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or neglect: We may use or 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 or other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
**Public Health responsibilities:** We will use or disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.
**Marketing Health - Related services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.
**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.
**Appointment reminders:** We may use or disclose your health information to provide you with appointment reminders including, but not limited to phone calls, voicemail messages, postcards, letter, emails or text messages.

## PRIVACY RIGHTS AS OUR PATIENT

Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our front desk for a copy of the request form. You may also request access by sending us a letter or email at office@vbtassociates.com. Once approved, an appointment can be made to review your records. You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied. You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and /or payment purposes, we do not keep a record of routine disclosures: therefore they are not available). You have the right to a list of instances in which we, or our business associated, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non routine disclosures going back 7 years starting January 1, 2018. Information prior to that date would not have to be released. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies). Please contact our front desk if you want to further restrict access to your health care information. This request must be submitted in writing. You have the right to file a complaint with us if you feel we have not complied with our privacy policies. Your complaint should be directed to your doctor. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can contact and speak to your doctor directly. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us.

## ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. David S. Binder, Dr. Alexander W. Tsui, Dr. Arianita Mulahu, Dr. Rebecca Binder & Dr. Megi Brahimaj's Notice of Privacy Practices.
Effective Date of Notice: 01/01/2018

**Patient Name (Print):** ______________________________
**Signature:** ______________________________
**Date:** ____________________