New Patient Adult Medical and Dental History

We value our patient's privacy and would never sell, share, or rent your personal information. It is used solely for the purpose of providing you with excellent service and assisting with your insurance. Please mark duplicate family information with ".

1) **Tell us about Yourself**

Patient's Legal Name: ______________________________ M / F Birthdate: ___/___/_____

Preferred Name (If Different than Above): ______________________ Social Security #: ____________________

Street Address: ______________________________ City: ____________ State: ____ Zip: __________

Marital Status: Married, Divorced, Single, Widowed Preferred Contact Method: Call, Text, Email

Cell/Home #: _______________ Work #: _______________ Email: ____________________

2) **Tell us about your Insurance:** Please provide a legal form of identification and insurance cards to utilize your benefits.

Primary Dental Insurance *or* **Patient does not have dental insurance** ☐

Policy Owner's Name: __________________________ Relationship to Patient: ____________________

Policy Owner's Birthdate: ___/___/_____ Social Security # ______________________________

Secondary Dental Insurance *or* **Patient does not have secondary dental insurance** ☐

Policy Owner's Name: __________________________ Relationship to Patient: ____________________

Policy Owner's Birthdate: ___/___/_____ Social Security # ______________________________

Medical Insurance *or* **Patient does not have medical insurance** ☐

Policy Owner's Name: __________________________ Relationship to Patient: ____________________

Policy Owner's Birthdate: ___/___/_____ Social Security # ______________________________

3) **Dental History**

Are you currently experiencing dental pain or discomfort? .... ☐ **Yes** - ☐ **No**

Please Explain: ____

What is the reason for your dental visit today? ______________________________

Date of last dental care: What was done at that time? ______________________________

How would you like to change your smile? ______________________________

Do your gums bleed when you brush or floss? .... ☐ **Yes** - ☐ **No**

Does food or floss catch between your teeth? .... ☐ **Yes** - ☐ **No**

Are your teeth sensitive to cold, hot, sweets or pressure? .... ☐ **Yes** - ☐ **No**

Have you had any periodontal (gum) treatments? .... ☐ **Yes** - ☐ **No**

Have you had any problems associated with previous dental treatment? .... ☐ **Yes** - ☐ **No**

Would you like to know more about sedation dentistry? ______________________________

Do you have earaches or neck pains? .... ☐ **Yes** - ☐ **No**

Do you have any clicking, popping or discomfort in the jaw? .... ☐ **Yes** - ☐ **No**

Do you brux or grind your teeth? .... ☐ **Yes** - ☐ **No**

Do you have sores or ulcers in your mouth? .... ☐ **Yes** - ☐ **No**

Do you wear dentures or partials? .... ☐ **Yes** - ☐ **No**

Have you ever had a serious injury to your head or mouth? .... ☐ **Yes** - ☐ **No**

Do you have a personal stance on fluoride use? ______________________________

4) **Health History**

Has there been any change in your general health in the past year? .... ☐ **Yes** - ☐ **No**

If yes, what conditions are being treated? ______________________________

Presently under care of a physician for a medical issue? .... ☐ **Yes** - ☐ **No**

Physician's Name: ______________________ Phone Number: ____________________

Taking medication regularly? .... ☐ **Yes** - ☐ **No**

Please List Medications: ____

Sensitive or allergic reaction to anything? (e.g. aspirin, codeine, penicillin, latex, sulfa) ☐ **Yes** - ☐ **No**

Please Explain: ____

Have you had any history of, or conditions related to any of the following: ……………………………………

- ☐ Yes - ☐ No: Joint Replacement (hip, knee, elbow, finger)
- ☐ Yes - ☐ No: Artificial (prosthetic) heart valve
- ☐ Yes - ☐ No: Previous Infective Endocarditis
- ☐ Yes - ☐ No: Damaged valves and/or transplanted heart
- ☐ Yes - ☐ No: Congenital Heart Disease (CHD)
  - Unrepaired, cyanotic CHD
  - Repaired Complete CHD date___
  - Repaired CHD with residual defects
- ☐ Yes - ☐ No: Heart attack
- ☐ Yes - ☐ No: Low / High Blood Pressure
- ☐ Yes - ☐ No: High Cholesterol
- ☐ Yes - ☐ No: Pacemaker
- ☐ Yes - ☐ No: Abnormal Bleeding
- ☐ Yes - ☐ No: AIDS or HIV Infection
- ☐ Yes - ☐ No: Autoimmune Disease
- ☐ Yes - ☐ No: Asthma
- ☐ Yes - ☐ No: Cancer Surgery / Chemo / Radiation
- ☐ Yes - ☐ No: Chronic Pain
- ☐ Yes - ☐ No: Diabetes Type I or II
- ☐ Yes - ☐ No: G.E. Reflux/Persistent Heartburn / Stomach issues
- ☐ Yes - ☐ No: Fainting Spells or Seizures
- ☐ Yes - ☐ No: Liver Dysfunction
- ☐ Yes - ☐ No: Neurological Disorders
- ☐ Yes - ☐ No: Sleep Apnea
- ☐ Yes - ☐ No: Sleep Disorder
- ☐ Yes - ☐ No: Mental Health Disorders
- ☐ Yes - ☐ No: Severe Headaches / Migraines
- ☐ Yes - ☐ No: Sexually Transmitted Disease
- ☐ Yes - ☐ No: History of Bisphosphonates Drugs
- ☐ Yes - ☐ No: Other: ________________

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If yes, please explain: ____

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Has it ever been required or recommended that you take an antibiotic pre-medication prior to dental treatment? ………………………………………………………………………………… ☐ **Yes - ☐ No**

Women Only: Are you pregnant, and number of weeks: _____? **[☐Yes - ☐No]** Nursing? **[☐Yes - ☐No]**
Are you taking birth control pills or hormonal replacement? **[☐Yes - ☐No]**

5) **Authorization**

I request and authorize dental treatment and procedures including the taking of dental x-rays and use of local anesthetics and/or nitrous oxide as may be necessary. **Initial:** _____

I understand that Heritage Oak Dental will bill my insurance as a courtesy but that I am ultimately responsible for all charges should my insurance company not pay for any reason. I also understand that my portion is due at the time treatment is rendered. I hereby authorize payment of dental benefits to Shane Douglas DDS PC. **Initial:** _____

I understand that I must provide Heritage Oak Dental with at least 24 business hours' notice of a change/cancellation to my appointment to avoid a $50-$250 "broken appointment fee" or loss of "nonrefundable deposit." **Initial:** _____

I acknowledge that I received and reviewed the following documents: Dental Material Fact Sheet, Financial Policy, and Notice of Privacy Practices. Activities at Heritage Oak Dental may be monitored by video surveillance. **Initial:** _____

6) **How did you hear about us?** ____

X____ Date: ____ /____ /________
Signature of Parent/Guardian/Responsible Party

For Completion by Your Doctor

Comments: ____

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☐PreMed (Amox, Clind, Other) ☐Allergies (Aspirin, Codeine, Ibuprofen, Erythro, Latex, Penicillin, Sulfa, Other) ☐Airway Do ☐ASA(I, II, III, IV, V)
☐Autoimmune Ds ☐Behavioral Do ☐Bleeding Do ☐BMI ☐Diabetes (I, II) ☐Epilepsy ☐BisphosHx ☐Mallampati (I, II, III, IV)
☐Dental (AntiFluoride, Anxiety, Bruxism, CRL, CRM, CRH, Habit, Ortho, Perio, Poor OH, Sensitivity, Soft Tissue) ☐Heart Ds ☐Radi/Chemo ☐Kidney Ds
☐Liver Ds ☐See MedHx ☐See Meds ☐Stomach Do ☐TMJD ☐Pregnant/Nursing ☐Botox ☐ Dermal Fillers ☐ Medical Billing

Reviewed By: _________ **NV:** ____