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:	SS#:
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	☐	☐	☐

	Yes	No	?
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	☐	☐	☐

	Yes	No	?
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	☐	☐	☐

	Yes	No	?
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?	☐	☐	☐

	Yes	No	?
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?	☐	☐	☐

	Yes	No	?
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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ENTERPRISE FAMILY DENTAL, PC

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RELEASE OF MEDICAL INFORMATION, FINANCIAL POLICY & HIPAA CONSENT

PRIVACY AND COMMUNICATION CONSENT:
Your medical information is personal, and Enterprise Family Dental, PC is committed to protecting it. We create records of the care and services you receive at our office. These records are used to provide you with high-quality care and to meet certain legal requirements. This notice applies to all records created by our office regarding your care.

Consent to Release Information

To release your personal information—including lab results, test results, or financial information—to anyone other than yourself, please read and sign below.

How We Use and Share Your Information

- **For Treatment:** We may share your information with healthcare professionals involved in your care, including physicians, nurses, and technicians.
- **For Payment:** We may use your information to bill and collect payment from you, your insurance company, or a third-party payer. We may also share information with your health plan to get prior approval or determine coverage.
- **For Appointment Reminders:** We may use your information to remind you of upcoming appointments via phone, text, or email.
- **As Required by Law:** We will disclose your information when federal, state, or local law requires it.

I give Enterprise Family Dental, PC, and its employees or agents, express consent to contact me regarding treatment, insurance, or payment. This may include calls, text messages, emails, or other methods using the contact information I have provided.

Signature: _____ **Printed Name:** _____ **Date:** _____

By signing below, I acknowledge that I have been informed of and agree to the privacy practices of Enterprise Family Dental, PC as described above.

Signature: _____ **Date:** _____

FINANCIAL POLICY AND CONSENT:

Insurance and Assignment of Benefits

As a courtesy, we will file your claims with your insurance company and assist with any supplemental forms, as long as we receive all necessary information at the time of your initial visit. Please remember that your insurance is a contract between you (the Subscriber), your employer, and the insurance company. Enterprise Family Dental, PC is not a party to that contract.

Payment Policy

Payment in full is due at the time of service. We accept:

- Cash
- Checks (a $35 fee applies for returned checks)
- Debit and Credit Cards
- CareCredit

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Contact Consent

To service your account and collect any outstanding balances, you consent to be contacted by Enterprise Family Dental, PC, its employees, or agents via: Telephone (including pre-recorded/artificial messages or automated dialing), text messages, or emails. This consent applies to any phone number or email address you provide.

Broken Appointments

We understand that life happens, but missed appointments affect both our patients and our team. Our policy is:

- Charges for broken appointments range from $30 to 20% of the appointment fee, depending on the type of visit and notice given.
- Appointments canceled less than 24 hours in advance will be considered broken, except in emergencies.
- Patients with three or more broken appointments may be dismissed from the practice

By signing below, I authorize the assignment of all dental, medical, disability, surgical, and major insurance benefits to Enterprise Family Dental, PC I also authorize the release of any necessary medical information to process these benefits. I understand that I am ultimately responsible for any charges not covered by insurance. Additionally, I have read and agree to the financial policies stated above.

Signature: _____ **Date:** _____

HIPAA CONSENT:

I authorize Enterprise Family Dental, PC to share information about my medical and dental records—including insurance and financial details—with the family members listed below. I also authorize these individuals to make or cancel appointments on my behalf. I understand that I may update this list or revoke this authorization at any time by notifying the office in writing. This authorization will remain in effect until I provide such written notice.

Name: _____ Phone #: _____ Relationship to Patient: _____

Name: _____ Phone #: _____ Relationship to Patient: _____

Name: _____ Phone #: _____ Relationship to Patient: _____

Signature: _____ **Date:** _____