Contact Information

Date _____ Patient is ☐ Self ☐ Parent ☐ Guardian

Name _____

Preferred Name_____

Birthday _____ Social Security_____

Marital Status _____ Gender: Male/ Female/ Other _____

Address _____

City _____ State _____ Zipcode _____

Cell Phone _____ Home Phone _____ Contact Method _____

Work Phone _____ Email _____

Emergency Contact Name _____ Number _____

How did you hear about us? _____

Preferred Pharmacy_____

Insurance Information **(If applicable)**

Insurance Company_____

Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Medical History

Physician's Name _____ Phone Number _____ Address

_____

Have you or anyone in your family had an adverse reaction to local anesthesia? Yes___No___

Is there anything you would like to discuss privately with the dentist? Yes_____ No_____

Medications

List all prescriptions (including birth control) vitamins, herbal supplements, natural products, over the counter drugs taken routinely and controlled substances. Include dosages if possible.

Allergies / Sensitivities

Are you allergic or sensitive (or ever had an adverse reaction) to:

___ Penicillin ___ Codeine ___ Local Anesthetic ___ Metals ___ Latex _____Aspirin ___ None

Antibiotics (if yes, what kind) _____

Other Medications _____

Bisphosphonates

Have you ever or are you currently taking or scheduled to begin taking any of the medications: Alendronate (Fosamax), Risedronate (Actonel), or Ibandronate (Boniva) <u>for Osteoporosis or Paget's disease</u>? Yes_____ No_____

Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma,or metastatic cancer Yes_____ No_____ Date Treatment Began _____

Are you pregnant or suspect that you may be? _____Yes _____ No

Are you nursing? _____ Yes_____ No

Do you smoke, vape, or use nicotine products? _____ Yes _____ No

Medical History

Do you have or have you ever had any of the following?

1. Artificial (prosthetic heart valve)	Yes/ No	**32.** Blood Disorders	Yes/ No
2. Previous infective endocarditis	Yes/ No	**33.** Anemia	Yes/ No
3. Damaged valves in transplanted heart	Yes/ No	**34.** Leukemia	Yes/ No
4. Congenital Heart Disease (CHD)	Yes/ No	**35.** Prolonged Bleeding	Yes/ No
Unrepaired, cyanotic CHD	Yes/ No	**36.** Hemophilia	Yes/ No
Repaired (completely) in last 6 month	Yes/ No	**37.** Sickle Cell Disease	Yes/ No
Repaired CHD with residual defects	Yes/ No	**38.** Cancer	Yes/ No
5. Heart Disease/Surgery	Yes/ No	**39.** Tumors	Yes/ No
6. Heart murmur	Yes/ No	**40.** Chemotherapy	Yes/ No
7. Heart Pacemaker	Yes/ No	**41.** Radiation Therapy	Yes/ No
8. Rheumatic fever/heart disease	Yes/ No	**42.** Neurological Disorders	Yes/ No
9. Mitral valve prolapse	Yes/ No	**43.** Epilepsy	Yes/ No
10. High / Low blood pressure (Circle one)	Yes/ No	**44.** Stroke	Yes/ No
11. Learning Disability	Yes/ No	**45.** Arthritis/Rheumatism	Yes/ No
12. Mental Health Disorder	Yes/ No	**46.** Autoimmune Disease	Yes/ No
13. Anorexia	Yes/ No	**47.** Artificial Joint/Prosthesis	Yes/ No
14. Bulimia	Yes/ No	**48.** Liver Disease	Yes/ No
15. Lung Disease/COPD	Yes/ No	**49.** Hepatitis (Circle One)	Yes/ No
16. Tuberculosis	Yes/ No	Type A B C Other:	Yes/ No
17. Asthma	Yes/ No	**50.** Gastrointestinal Disease	Yes/ No
18. Shortness of breath	Yes/ No	**51.** GERD	Yes/ No
19. Respiratory Ailments	Yes/ No	**52.** Deaf or Hard of Hearing	Yes/ No
20. Emphysema	Yes/ No	**53.** Glaucoma	Yes/ No
21. Sinus Trouble	Yes/ No	**54.** Cortisone Medication	Yes/ No

22. Diabetes Type I or Type II (circle which one)	Yes/ No	**55.** Fainting Spells	Yes/ No
23. Thyroid Problems	Yes/ No	**56.** Organ Transplant	Yes/ No
24. Persistent swollen glands	Yes/ No	**57.** Removal of Spleen	Yes/ No
25. Kidney Problems	Yes/ No	**58.** Osteoporosis	Yes/ No
26. Venereal Disease	Yes/ No	**59.** Sleep Disorder	Yes/ No
27. HIV Positive/AIDS/ARC	Yes/ No	**60.** Elevated Cholesterol	Yes/ No
28. Alcohol Addiction	Yes/ No	**61.** Anxiety	Yes/ No
29. Drug Dependency	Yes/ No	**62.** Depression	Yes/ No
30. Chemical Dependency	Yes/ No	**63.** Alzheimer's	Yes/ No
31. Dementia	Yes/ No	**64.** Other:	

For questions requiring longer responses, please use the comments box below.

I understand the information entered on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Please sign below when complete.

X _____ **Date** _____

Patient or Patient Guardian

X _____ **Date** _____

Doctor or Provider of Care

Dental Treatment General Consent Form

1. WORK TO BE DONE

I understand that one or more of the following items may be recommended to be done: fillings, crowns, bridges, partials, dentures, implants, extractions, root canals, and/or cleanings. I understand that I will be given a more detailed consent for these procedures discussing possible risks, benefits, and alternative options.

2. DRUGS AND MEDICATIONS

I understand that any medications (including antibiotics and analgesics) can cause allergic reactions resulting in redness/swelling of tissues, hives, pain, itching, vomiting, difficulty breathing, anaphylactic shock (severe allergic reaction). I understand that if any of these reactions were to occur, I should immediately stop taking the medication and contact my dental care provider. I have informed my dental providers of any known drug allergies and will keep them updated regarding any changes. Certain medications (including analgesics and anti-anxiety agents) may cause drowsiness and slowed reflexes and that it is advisable not to drive or operate hazardous equipment when using such medications.

3. USE OF LOCAL ANESTHETICS

I understand that local anesthetics may be used for the purpose of providing dental procedures in a comfortable manner, for diagnosing, or for treating facial pain. I authorize my doctor to administer anesthetics that may be deemed appropriate. I understand that potential complications include, but are not limited to, pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

4. CHOICE OF MATERIALS

In any filling situation, there are various choices of materials (amalgam, composite resin, gold foil, porcelain/gold inlays or onlays). Your doctor will make the best treatment choice recommendation for your dental needs. In any crown/bridge situation, there are various choices of materials (stainless steel, high noble metals, noble metals, porcelain fused to metal, all-porcelain). Your doctor will make the best treatment choice recommendation for your dental needs.

5. CHANGES IN THE TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

6. RADIOGRAPHS

I understand that radiographs (x-rays) may need to be taken in order to provide a thorough complete examination or to receive optimal levels of treatment. I authorize my doctor to use professional judgement to take any needed radiographs.

7. EXPOSURE

In the event that any of my dental providers is exposed to my blood and other bodily fluids, I agree to have my blood drawn and tested for hepatitis B virus (HBV), hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner and that the results would be

made available only to the person who was exposed. I understand that the costs of these procedures and tests would be assumed by my dental provider.

Signature of Patient _____ Date_____

Signature of Parent/Guardian_____ Date_____
if patient is a minor

Signature of Dentist _____Date_____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

My Authorization

I authorize Takii Family Dentistry to use or disclose my health information to the following recipient:

Name (or title) and organization _____

Phone _____ Email _____

Relationship _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: ☐ - Patient is unable to sign because: _____

Relationship of representative to sign on behalf of the patient:

☐ - Mother ☐ Father - ☐ Legal Guardian- ☐ - Other: _____

Print Name: _____ Date: _____

Signature of Authorized Representative:_____

HIPAA Privacy Acknowledgement and Notice of Privacy Practice

I, X_____ **[Please print full legal name here]** (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy of Takii Family Dentistry, and have been offered a copy of such to keep for my record

PLEASE INITIAL <u>ONE</u> OF THE FOLLOWING:

X_____I hereby **acknowledge** that I have read the Policy and understand its terms and conditions.

X _____I hereby **refuse to acknowledge** receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy.

X _____X _____
SIGNATURE OF PATIENT DATE

X_____X _____
SIGNATURE OF DOCTOR DATE