

**ADVANCED DENTAL CARE OF TOLEDO**

**NEW & EXISTING PATIENT**

**INFORMATION & HEALTH HISTORY FORM**

**GENERAL PATIENT INFORMATION**

FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

GENDER: \_\_\_\_\_ MARITAL STATUS: MINOR / SINGLE / MARRIED / DIVORCED / WIDOWED

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ TEXTS OK? \_\_ YES \_\_ NO

E-MAIL: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ ARE THEY A PATIENT AT OUR OFFICE? \_\_ YES \_\_ NO

**OFFICE POLICY**

**Grace Period**

To help us serve all patients efficiently, Advanced Dental Care of Toledo has set guidelines for appointment attendance. We allow a 10-minute grace period for scheduled appointments. If you arrive more than 10 minutes late, your appointment will be cancelled and must be rescheduled.

**Cancellation Policy**

For cancellations or rescheduling, we ask for at least 24 hours' notice. If you cancel or reschedule with less than 24 hours' notice, you'll receive a Same Day Warning on the first occurrence. A second occurrence or a no-show will place you on Same Day Only Scheduling. Under Same Day Only Scheduling, you'll need to call on the day you're available to check for open appointments. Once you attend a same-day appointment, you'll return to regular advance scheduling. We appreciate your cooperation in respecting our providers' time and helping us care for all patients smoothly.

SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

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PRIMARY PHYSICIAN NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IF NEEDED, MAY WE CONTACT THEM REGARDING ANY CONCERNS THAT MAY ARISE? \_\_\_ YES \_\_\_ NO

### MEDICAL HISTORY

**\*\* PLEASE CHECK THE CORRESPONDING BOX THAT ANSWERS EACH QUESTION \*\***

	YES	NO
ARE YOU CURRENTLY UNDER MEDICAL TREATMENT?		
HAVE YOU EVER BEEN HOSPITALIZED FOR A SURGICAL OPERATION OR ILLNESS?		
HAVE YOU EVER TAKEN FEN-PHEN/REDUX?		
DO YOU USE TOBACCO?		
DO YOU CONSUME ALCOHOL?		
DO YOU USE RECREATIONAL DRUGS?		
DO YOU WEAR CONTACT LENSES?		
DO YOU HAVE A PERSISTENT COUGH NOT ASSOCIATED WITH A KNOWN ILLNESS?		
(WOMEN ONLY) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?		
(WOMEN ONLY) ARE YOU NURSING?		
(WOMEN ONLY) ARE YOU TAKING BIRTH CONTROL?		

**\*\* PLEASE CHECK THE BOX IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU: \*\***

<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HISTORY OF MENTAL HEALTH DISORDERS (ANXIETY/MOOD DISORDERS)	<input type="checkbox"/> CHEST PAINS
<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> EASILY WINDED
<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> STROKE
<input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> ANGINA	<input type="checkbox"/> HAY FEVER / ALLERGIES
<input type="checkbox"/> FAINTING / SEIZURES	<input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> EPILEPSY / CONVULSION	<input type="checkbox"/> CANCER	<input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> JOINT REPLACEMENT	<input type="checkbox"/> HEART DISEASE
<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> HEPATITIS / JAUNDICE	<input type="checkbox"/> HEART TROUBLE
<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> STD	<input type="checkbox"/> OTHER:
<input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> STOMACH / ULCERS	<input type="checkbox"/> <b>NONE OF THESE APPLY</b>

### SIGNATURE

SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**ALLERGIES (IF APPLICABLE)**

**CHECK THIS BOX IF THIS SECTION DOES NOT APPLY TO YOU**

**\*\*PLEASE MARK THE CORRESPONDING LINE IF YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING \*\***

LOCAL ANESTHESIA                       GENERAL ANESTHESIA                       ASPIRIN  
 LATEX     ANTI-INFLAMMATORY                       TAPE/ADHESIVES  
 PENICILLIN/AMOXICILLIN                       METAL     FLUORIDE

OTHER (PLEASE EXPLAIN): \_\_\_\_\_

**SURGICAL & HOSPITALIZATIONS (IF APPLICABLE)**

**CHECK THIS BOX IF THIS SECTION DOES NOT APPLY TO YOU**

**\*\* PLEASE LIST PREVIOUS SURGERIES AND HOSPITALIZATIONS WITH APPROXIMATE DATES \*\***

SURGERY/HOSPITALIZATION REASON: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SURGERY/HOSPITALIZATION REASON: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SURGERY/HOSPITALIZATION REASON: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MEDICATIONS (IF APPLICABLE)**

**CHECK THIS BOX IF THIS SECTION DOES NOT APPLY TO YOU**

**\*\* PLEASE INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, AND VITAMINS \*\***

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

**PHARMACY INFORMATION**

PHARMACY NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WILL YOU REQUIRE ASSISTANCE CALLING IN PRESCRIPTIONS IF IT IS NECESSARY? \_\_\_\_ YES \_\_\_\_ NO

**SIGNATURE**

SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_

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**DENTAL HISTORY**

**\*\* PLEASE CHECK THE CORRESPONDING BOX THAT ANSWERS EACH QUESTION \*\***

	YES	NO
DO YOUR GUMS BLEED WHEN BRUSHING OR FLOSSING?		
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS OR FOOD?		
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS OR FOOD?		
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?		
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?		
HAVE YOU HAD HEAD OR NECK INJURIES?		
DO YOU HAVE ANY JAW PAIN?		
DO YOU HAVE ANY CLICKING OF THE JAW?		
DO YOU HAVE DIFFICULTY OPENING?		
DO YOU HAVE DIFFICULTY CHEWING?		
DO YOU HAVE FREQUENT HEADACHES?		
DO YOU CLENCH OR GRIND YOUR TEETH?		
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?		
HAVE YOU HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?		
HAVE YOU HAD ANY ORTHODONTIC WORK?		
HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?		
HAVE YOU EVER BEEN INSTRUCTED ON THE CORRECT METHOD OF BRUSHING?		
HAVE YOU EVER BEEN INSTRUCTED ON THE CORRECT METHOD OF FLOSSING?		
HAVE YOU EVER BEEN INSTRUCTED ON PROPER GUM CARE?		

HOW MANY PER DAY DO YOU BRUSH YOUR TEETH?	
HOW MANY TIMES PER DAY DO YOU FLOSS?	
APPROXIMATELY WHEN WAS YOUR LAST DENTAL VISIT?	

PLEASE INCLUDE ANY SPECIFIC QUESTIONS OR CONCERNS TO BE COVERED IN TODAY'S APPOINTMENT, IF YOU HAVE NONE, WRITE N/A.	
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**SIGNATURE**

SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# **HIPAA Compliance Consent Form**

*Advanced Dental Care Of Toledo*

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available upon asking any staff member for a printed copy of our policies or from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

## **ACKNOWLEDGMENT OF OUR PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Advanced Dental Care of Toledo's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

May we discuss your dental conditions with any member of your family?    **Yes**    **No**

If **Yes**, please list the family members allowed:

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**Patient Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(Patient, legal guardian or authorized agent of patient)

### **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 prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

## **Advanced Dental Care of Toledo Audio Documentation Consent**

To help with accurate clinical documentation, Advanced Dental Care of Toledo may use **audio-only recording during your visit**. Recordings are used only for clinical notes and documentation.

- No video recording is used
- Provider will notify you when recording begins and ends
- Recordings are securely protected
- Participation is voluntary
- Consent may be withdrawn at any time in writing

**Please choose one:**

**YES-** I consent to audio- only recording for documentation purposes

**NO-** I do not consent to audio recording.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Parent/Guardian if applicable)