Patient Information and Medical History Update

We appreciate your cooperation in keeping your records accurate. Thank you.

Appointment date and time: _____

Patient Name: _____ **Date of birth**_____

Address _____
Street or PO Box City State Zip

Best Contact # _____ **Work #** _____ **Email** _____
Emergency contact _____ **Relationship** _____ **Phone #**_____

Insurance: ☐**No** ☐**Yes – Insurance Co Name:** _____

***If you are completing this form for someone else, what is your relationship to that person?**
Your Name _____ **Relationship**_____

Policy regarding Same-Day Cancellations
I understand that Artistic Dental has a $50 fee/hour that may be applied to my account if I miss an appointment without sufficient notice to the dental office of at least 24 hours prior to my scheduled appointment time. I am enrolled in an automated appointment reminder system that will help avoid the unfortunate forgetting of an appointment and I can modify my method of contact at any time, but ultimately take the responsibility of scheduling responsibly.

Financial Responsibility
If my account becomes delinquent (60 days or older), I agree to pay all late fees, finance charges, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding. To avoid collection action, I will keep in contact with the office when I receive correspondence from them regarding balances. Returned checks will be assessed a $30 non-sufficient funds charge.

Acknowledgment of Receipt of Privacy Notice
I acknowledge that the office's Notice of Privacy Practices has been made available to me.

Medical History Update

Physician: _____ **Last visit date:** _____
Visit reason: _____

Pharmacy: _____ **Phone # or cross streets:** _____

Please list current medications: _____
_____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ **Yes** ☐ **No**

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
☐ **Yes** ☐ **No** **Date treatment began** _____

Allergies Are you allergic to or have you ever had a reaction to:

	Yes	No
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics _____	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics _____	☐	☐

	Yes	No
Iodine	☐	☐
Latex	☐	☐
Metals	☐	☐
Other _____	☐	☐

Turn page over please

Please check mark a yes or no response to indicate if you have or have not had any of the following health concerns or diseases

	Yes	No
Allergies: Seasonal/Food/Animals/Other _____	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Arteriosclerosis	☐	☐
Asthma	☐	☐
Autoimmune disease	☐	☐
Back Problems	☐	☐
Blood disease	☐	☐
Bleeding, abnormal	☐	☐
Blood transfusion, if yes when? _____	☐	☐
Bronchitis/Pneumonia	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐
Type _____		
Cardiovascular disease	☐	☐
Chemical dependency	☐	☐
Circulatory Problems	☐	☐
Congestive heart failure	☐	☐
Cortisone Treatments	☐	☐
Damaged heart valves	☐	☐
Diabetes Type I or II Glucose # _____	☐	☐
Do you snore?	☐	☐
Do you wear contacts?	☐	☐
Eating Disorder	☐	☐
Eye Condition, other than corrective lenses	☐	☐
Emphysema	☐	☐
Epilepsy/seizures	☐	☐
Dizziness, fainting spells	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Glaucoma	☐	☐
Head Injury	☐	☐
Hearing loss	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Hemophilia	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
High blood pressure	☐	☐
HIV infection or AIDS Viral load _____	☐	☐
Joint Replacement (hip, knee, elbow, etc)	☐	☐
Date: _____ Complications ☐**Yes** ☐**No**		

	Yes	No
Kidney problems	☐	☐
Low blood pressure	☐	☐
Malnutrition	☐	☐
Mental health disorders	☐	☐
Specify please _____		
Mitral valve prolapse	☐	☐
Neurological disorders	☐	☐
Specify please _____		
Night sweats	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Respiratory Problems	☐	☐
Recurrent infections	☐	☐
Type of infection _____		
Persistent cough	☐	☐
Rheumatoid arthritis	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Severe or rapid weight loss	☐	☐
Severe headaches/migraines	☐	☐
Sleep disorder	☐	☐
Skin Condition	☐	☐
Stroke	☐	☐
Systemic lupus erythematosus	☐	☐
Swollen glands in neck, persistent	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐

Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommend for any form of CHD.

Regarding the joint replacement, did your Orthopedic surgeon give instruction to pre-medicate with antibiotics before dental treatments? ☐**Yes** ☐**No** ☐**Don't Know**

Do you use tobacco products (smoking, snuff, chew, bidis)? ☐**Yes** ☐**No**
If so, how interested are you in stopping? Check one: ☐Very ☐Somewhat ☐Not Interested

Women Only Are you: Taking birth control pills or hormonal replacement? ☐**Yes** ☐**No**
Pregnant? ☐**Yes** ☐**No** Number of weeks along _____ Nursing? ☐**Yes** ☐**No**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on the information for treatment me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have mad in the completion of this form.

Patient/Parent/Guardian Signature _____ **Date** _____

Notes: _____