Woodside Dental Care – Registration and Health History Form

WE HAVE THE INTEREST AND DESIRE TO LISTEN, REALLY LISTEN, TO WHAT YOU ARE SAYING. PLEASE DON'T HESITATE TO ASK ABOUT ANYTHING YOU DON'T UNDERSTAND. YOU ARE DEALING WITH MEMBERS OF A TEAM WHOSE PRIMARY JOB IS TO SERVE YOU. WE PROMISE THAT YOU WILL NEVER LEAVE FEELING THAT NO ONE CARES.

In order to begin treatment the following information is necessary. Please complete fully and print legibly. All information will be held in strict confidence.

Name______________________ Home Ph:__________ Cell Ph:__________ Spouse's Name:__________
Last First Middle

If patient is a minor, please give the name of a parent or legal guardian______________________
Last First Middle

Residence Address ______________________ City__________ State ______ Zip Code ________
Street

Mailing Address (if different than residence)______________________ City__________ State______ Zip Code________
Street

Date of Birth__________ SS#__________ Sex: ☐ M ☐ F Email______________________

Drivers License__________ Occupation__________ Employer__________

Employer Address______________________ City__________ State______ Zip Code________
Street

Emergency Contact______________________ Relationship__________ Phone __________

If you are completing this form for another person, what is your relationship to that person? ______________________
Name Relationship

How may we contact you? Phone _____ Mail _____ Email _____ Text Message _____ All _____

INSURANCE

Policy Holder: __________ Relationship to Patient: __________ Insured DOB: __________

SS# of Insured: __________ Insured Employer: __________ Insurance Company__________

Secondary Insurance: ☐ Yes ☐ No If Yes: Policy Holder:__________ Relationship to Patient: __________

Insured DOB: __________ SS# of Insured:__________ Insured Employer:__________

DENTAL INFORMATION

For the following questions, please (X) whichever applies. This information is vital to allow us to provide appropriate care for you.

Yes	No	
☐	☐	Do your gums occasionally bleed when you brush?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain __________

How would you describe your current dental problem? ______________________

Former dentist______________________ Reason for leaving______________________

Date of your last dental exam__________ Date of last dental x-rays __________ What was done at that time? __________

Are you nervous about receiving dental care? ☐ Yes ☐ No Would you like to be sedated for treatments? ☐ Yes ☐ No

Are you a participant in any sport? ☐ Yes ☐ No Do you wear a mouth guard? ☐ Yes ☐No

How do you feel about the appearance of your teeth? ______________________

MEDICAL INFORMATION

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition but they are all associated with proper oral care.

Yes	No	
☐	☐	Are you in good health?
☐	☐	Has there been any change in your general health within the past year?
☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? __________ Date of last physical examination __________ Physician __________ (NAME) (PHONE)
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? __________

Yes	No	
☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking and what is the dosage?
		Prescribed ____
		Over the counter ____
		Natural or herbal preparations ____
☐	☐	**Are you taking, or have you taken, any diet drugs such Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?**
☐	☐	Have you taken any of the following prescription medications? Circle one. ZOMETA AREDIA ACTONEL BONIVA FOSAMAX
☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ____ In the past month? ____
☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? ☐ Yes ☐ No
☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list ____
		Frequency of use (daily, weekly, etc.) ____ Number of years of recreational drug use ____
☐	☐	Do you use tobacco (smoking, snuff, chew)? If yes, how much? ____
☐	☐	Do you wear contact lenses?

ALLERGIES: ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (PLEASE FILL OUT EACH COLUMN)

Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Sulfa drugs	☐	☐	Hay fever/seasonal
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Animals
☐	☐	Penicillin or other antibiotics	☐	☐	Latex	☐	☐	Food (Specify) ____
☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	Iodine	☐	☐	Other (specify) ____

To yes responses, specify type of reaction ____

Yes	No	**WOMEN ONLY**
☐	☐	Nursing?
☐	☐	Are you pregnant? If yes, how many months? ____
☐	☐	Taking birth control pills?

Do you now or have you ever had any of the following? Please check YES or NO to **ALL**

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Disease, drug, or radiation induced immunosurpression	☐	☐	Night sweats
☐	☐	AIDS or HIV infections				☐	☐	Osteoporosis
☐	☐	Angina. If yes, date: ____	☐	☐	Dry mouth	☐	☐	Persistent swollen glands/neck
☐	☐	Anemia	☐	☐	Eating disorder. If yes, specify: ____	☐	☐	Recurrent infections
☐	☐	Arteriosclerosis			____	☐	☐	Respiratory problems
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Excessive urination	☐	☐	Severe headaches / migraines
☐	☐	Blood transfusion	☐	☐	Fainting spells or seizures	☐	☐	Severe or rapid weight loss
		If yes, date ____	☐	☐	G.I. reflux	☐	☐	Sexually transmitted disease
☐	☐	Cancer/chemotherapy/radiation	☐	☐	Glaucoma	☐	☐	Sinus trouble
		treatment. If yes, date: ____	☐	☐	Heart attack. If yes, date: ____	☐	☐	Sleep disorder
☐	☐	Cardiovascular disease	☐	☐	Hemophilia	☐	☐	Sores or ulcers in the mouth
☐	☐	**Artificial heart valves**	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Stroke. If yes, date: ____
☐	☐	**Pacemaker**	☐	☐	High blood pressure	☐	☐	Systemic lupus erythematosus
☐	☐	**Damaged heart valves**	☐	☐	Implants	☐	☐	Thyroid problems
☐	☐	**Heart mumur**	☐	☐	Joint replacement. If yes,date: ____	☐	☐	TMJ
☐	☐	**Inborn heart defects**			Where: ____	☐	☐	Tuberculosis
☐	☐	**Mitral valve prolapse**	☐	☐	Kidney problems	☐	☐	Ulcers
☐	☐	**Rheumatic heart disease**	☐	☐	Low blood pressure	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:
☐	☐	Chronic pain	☐	☐	Mental health disorders. If yes, specify:			____
☐	☐	Chest pain upon exertion			____			____
☐	☐	Diabetes, If yes, specify below:			____			____
		____	☐	☐	Neurological disorders If yes, specify" ____			

☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment? If so, what antibiotic and dose? ____

Who may we thank for referring you to our office? ____

I certify that I have read and understand the above. To the best of my knowledge, all of the preceding answers are true and correct. I understand that it is my responsibility to advise this office of any changes in the information contained on this form. 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 made in the completion of this form. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable before or at the time of service unless other arrangements have been made. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnoses of any dental needs. I hereby authorize my dentist to release any and all medical or dental information to my insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

____ Signature of Patient/Legal Guardian ____ Date

____ Assistant Signature ____ Date ____ Dentist Signature ____ Date

PATIENT CONSENT FORM

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). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of ____________, 20___.

Print Patient Name: ________________________________

Relationship to Patient: ______________________________

Signature: ____

Practice Name: WOODSIDE DENTAL CARE

Address 10883 Telegraph Rd. Ventura, CA 93004

City/State/Zip ____________________________