courtsidedental
FAMILY & AESTHETIC DENTISTRY

DENTAL HISTORY

Patient Name _____ Date _____

Are you having any discomfort in your mouth? If so please describe:

_____

Are your teeth sensitive to:

☐ Cold ☐ Hot ☐ Biting ☐ Sweets ☐ Other

Do you experience any of the following with your jaw:

☐ Clicking ☐ Pain ☐ Difficulty Opening ☐ Difficulty Closing ☐ Difficulty Chewing

☐ Frequent Headaches ☐ Clenching/Griding

Have you ever been diagnosed with Periodontal (Gum) Disease? ☐ Yes ☐ No

If so, when and how was it treated?

_____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

If yes, what would you like changed?

_____

Have you ever wanted your teeth to be whiter? ☐ Yes ☐ No

Have you ever had Orthodontics (Braces)? ☐ Yes ☐ No

If not, are you interested? _____

Do you wear dentures/partials? ☐ Yes ☐ No

If so, how old are they? _____

Have you ever had any problems with local anesthetic or nitrous oxide (laughing gas) or excessive bleeding after a dental procedure? ☐ Yes ☐ No

If so, please explain:

_____

Please share any other concerns/questions you may have about your dental health

_____

Signature _____ **Date** _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Patient Name _____

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions to our Notice, at any time by contacting: (269) 327-1011, 3000 West Centre, Portage, MI 49024.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent from and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ **Date** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you many decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ **Date** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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NEW PATIENT SLIP

Who can we thank for referring you? _____

Patient Name _____ Date of Birth _____

Spouse Name _____ Date of Birth _____

Children

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Home Phone _____ Work _____ Cell _____

Address _____

City _____ Zip _____

Are you having any dental problems? ☐ Yes ☐ No

If so, please explain:

_____

What is the name and location of your previous dentist? _____

Why have you decided to change dentists? _____

What is the date of your last cleaning and exam? _____

Have you had any Periodontal surgery before? If Yes, when/where? ☐ Yes ☐ No _____

Have you had a FMS/PAN in the past 5 years? ☐ Yes ☐ No

Have you had any major restorations recently? ☐ Yes ☐ No

Do you have an allergy to any medications or latex? ☐ Yes ☐ No

Do you take pre-medication for dental work? (for heart problem/artificial joint) ☐ Yes ☐ No

Do you have a bite splint? If yes, please bring to first appointment. ☐ Yes ☐ No

Do you have dental insurance? ☐ Yes ☐ No

Dual coverage? ☐ Yes ☐ No

If yes, with what employer? _____

What insurance carrier? _____

Social security number _____

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MEDICAL HISTORY

Patient Name _____ Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If yes _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes _____
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes _____
Are you on a special diet?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	

Women: Are you..

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? _____

Do you use any controlled substances? ☐ Yes ☐ No If yes _____

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
			Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____

Signature _____ **Date** _____