Patient Information & Health History Form

Patient Name: ____ Date: ____________________
Last, First MI (Preferred Name)

Email: ________________________ Employer: ______________________________________

Social Security #: ________________________________ Birth Date: ______________________

Phone #: Cell: ________________________________ Home: ______________________

Work: ________________________________ Other: ______________________

Address: ____
Street City State Zip Code

SPOUSE NAME: ________________ EMERGENCY CONTACT: __________________ PHONE # (_____) ______________

If you are a New Patient whom may we thank for referring you to our practice? ☐ **Name** __________________
☐ **Website/Internet** ☐ **Yellow Pages** ☐ **Sign/driving by** ☐ **Insurance** ☐ **Other** ______________

Date of Last Dental Visit: ________________________ Reason for today's visit: ____________________________

Medical Health History

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Are you now under the care of a physician: ☐ Yes ☐ No If so, what is the condition being treated? ______________

Physician Name: ____ Phone #: (_____) __________________

Have you been admitted to a hospital or needed emergency care during the past five years?.......................... ☐ Yes ☐ No
If so, what was the illness/injury? ____
Do you have chest pain upon exertion?.. ☐ Yes ☐ No
If so, please explain: ____
Are you ever short of breath after mild exercise or when lying down?... ☐ Yes ☐ No
If so, please explain: ____
Do you drink alcoholic beverages?.. ☐ Yes ☐ No
If yes, how much?: ____
Do you smoke or use tobacco products?... ☐ Yes ☐ No
If yes, please list: ____
Do your ankles swell?... ☐ Yes ☐ No
Do you have inborn heart defects?... ☐ Yes ☐ No
Are you taking ANY medicine(s) including non-prescription?.. ☐ Yes ☐ No
If yes, please list or attach a medication list: ____
____

Do you have any health problems that need further clarification?.. ☐ Yes ☐ No
If so, please explain: ____

Female Patients:
Are you pregnant or is there a chance you could be pregnant?.. ☐ Yes ☐ No
If yes, what is your due date? ____/____/_______

Are you allergic or have you had a reaction to any of the following?:

Amoxicillin................ ☐ Yes ☐ No
Antibiotic .... ☐ Yes ☐ No
Aspirin.................... ☐ Yes ☐ No
Bactrim................... ☐ Yes ☐ No
Codeine.................. ☐ Yes ☐ No
Compazine............... ☐ Yes ☐ No
Erythromycin .... ☐ Yes ☐ No

Ibuprofen .... ☐ Yes ☐ No
Iodine....................... ☐ Yes ☐ No
Latex........................ ☐ Yes ☐ No
Local Anesthetic.......... ☐ Yes ☐ No
Lortab....................... ☐ Yes ☐ No
Nickel....................... ☐ Yes ☐ No
Penicillin.................. ☐ Yes ☐ No

Sulfa....................... ☐ Yes ☐ No
Tetanus.................... ☐ Yes ☐ No
Tramadol.................. ☐ Yes ☐ No
Tylox....................... ☐ Yes ☐ No
Other: ______________________
____

Do you have or have you ever had any of the following? Please check those that apply:

Condition		
Acid Reflux	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Alcohol Dependency	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
ChemicalDependency	☐ Yes	☐ No
Dental Implants	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No
Fainting/Dizziness	☐ Yes	☐ No
Head Injuries	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Type ___________		
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Knee Replacement	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Low Blood Sugar	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Mental Disorders	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Disorders	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Persistent cough	☐ Yes	☐ No
Problem with Immune System	☐ Yes	☐ No
Problem with Swollen Glands	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sexually transmitted Disease	☐ Yes	☐ No
Sinus Issues	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Stomach Problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcerative Colitis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

OTHER:
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Dental Health History

Have you had any trouble/complications following any previous dental treatment?........ ☐ Yes ☐ No
If so, please explain: ______________________________
Do you suffer from any TMJ problems?........ ☐ Yes ☐ No
Are you wearing any removable dental appliances?........ ☐ Yes ☐ No
Does your physician require you to premedicate with antibiotic for dental treatment?........ ☐ Yes ☐ No
If so, what medication? ______________________________

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Broken fillings
- ☐ Cigarette, pipe or cigar smoking
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Loose teeth
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Sleep Apnea
- ☐ Other: ____________________

How often do you brush: ____________
How often do you floss: ____________

Rate Your Smile: (Love It) 10 9 8 7 6 5 4 3 2 1 (I don't like it at all)

Insurance Information

Primary

Name of Policy Holder:______________________________ Date of Birth ______________

Insurance Plan Name and Address: ______________________________

ID #______________ Group # __________ Patient's relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer Name: ______________________________

Secondary

Name of Policy Holder:______________________________ Date of Birth ______________

Insurance Plan Name and Address: ______________________________

ID # ______________ Group #__________ Patient's relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer Name: ______________________________

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires 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 errors or omissions that I may have made in the completion of this form, and I understand the HIPAA regulatory laws and have received a copy of the HIPAA policy for this office. If I ever have any change in my health or HIPAA consent, I will inform the doctors at the next appointment without fail.

______________________________ **Date:** ______________
Signature of patient, parent or guardian

Patient Name: ______________________________.

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HIPAA AUTHORIZATION

HIPAA Authorization Form for Family Members/Friends

I give my permission to Wagner Family & Cosmetic Dentistry and Dr. Scott Wagner and his staff to disclose and release my protected health information and all past, present and future health record (including but not limited to diagnoses, lab tests, prognosis, treatment, billing, insurance and appointment records for all conditions, treatment, procedures and financials) to:

Name(s): ______________________ Relationship: ______________________

______________________ ______________________

____________ I do not give permission to share any past, present and future health record with any person(s) other than other health care providers should the need arise.

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

Consent to Leave Message

Wagner Family & Cosmetic Dentistry and Dr. Scott Wagner and his staff in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect our office and staff from violating the patient's confidentiality. If there is not a signed consent on file, we will only leave our name and phone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return our call.

By completing the consent below, you are allowing Wagner Family & Cosmetic Dentistry, Dr. Scott Wagner and his staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing, emailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

________ I give permission to leave relevant medical, financial and appointment information on my answering machine or voice mail at home, cell phone, work or with the person(s) I have listed above.

________ I do not give my permission to leave relevant medical, financial and appointment information on my answering machine or voice mail at home, cell phone or work. I understand that Dr. Wagner and/or his staff will only leave basic information and I will need to return their call for more details.

____
Name of the Individual Giving this Authorization

______________________________________ ____________________
Signature of the Individual Giving this Authorization Date