~ Health History Form ~

Date:

Referred By:

Name:
Last First Middle

Social Security Number:

Cell Number: Work Number: Home Number:

Date of birth:

Sex: M F

Address:
Street: City: State: Zip:

Spouse/Guardian Name:

Date of Birth:

Email address: (for confirming appointments, etc)

Height:

Weight:

Employer:

Dental Information

Please mark (X) to indicate your responses to the following questions.

Have you experienced any of the following:	YES	NO
Bleeding gums when you brush or floss?		
Tooth sensitivity to cold, hot, sweets or pressure?		
Food or floss catching between your teeth?		
Dry mouth?		
Sores or ulcers in your mouth?		
Serious injury to your head or mouth?		

Do you:		
Have earaches or neck pains?		
Have any clicking, popping or discomfort in the jaw?		
Clench or grind your teeth?		
Get headaches frequently?		
Wear dentures or partials?		

Have you ever had any of the following:	YES	NO
Periodontal (gum) treatments?		
Orthodontic (braces) treatment?		
Problems associated with previous dental treatment? If yes please explain		
Are you currently experiencing dental pain or discomfort? If yes please explain		

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Where were they done?

What is the reason for your dental visit today?

Medical Information

	YES	NO
Are you in good health?		
Any change in your general health in the past year? If yes please explain		
Any serious illness or hospitalization in past 5 years? If yes please explain		

Date of last physical exam: _____

Who are your doctors?

Primary Care Provider _____

Chiropractor _____

Other _____ Specialty _____

Pharmacy _____ Location _____

Are you taking any prescription medications? YES NO
Please list

Are you taking any over the counter medications? YES NO
Please list

Are you taking any supplements, vitamins or herbal preparations? YES NO
Please list

Medical Information (cont.) *Please mark (X) to indicate your responses to the following questions*

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

	YES	NO
Local anesthetics		
Aspirin		
Penicillin or other antibiotics		
Codeine or other narcotics		
Other Medications (specify)		
Metals		
Latex (rubber)		
Food (specify)		
Hay fever/seasonal		
Animals		
Other (specify)		

	YES	NO
Are you Pregnant?		
Do you use tobacco? (smoking, snuff, chew)		
Do you drink alcoholic beverages?		
If yes, how much do you typically drink in a week?		

Have you ever had any of the following:

	YES	NO
Artificial joint replacement? (finger, hip, knee, elbow)		
Artificial (prosthetic) heart valve?		
Infective carditis?		
Damaged valves in transplanted heart?		
Congenital heart disease?		

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? **YES** **NO**

Name of physician or dentist making that recommendation: _____

Please mark (X) to indicate whether you have or have had any of the following diseases or conditions

	YES	NO
Abnormal bleeding		
AIDS or HIV infection		
Anemia		
Angina		
Anxiety		
Arrhythmia		
Arthritis		
Asthma		
Autoimmune disease		
Bronchitis/Emphysema		
Cancer		
Type		
Chemotherapy?		
Radiation?		
Cardiovascular Disease		
Chest pain on exertion		
Chronic Fatigue		
Chronic Pain		
Congenital heart defect		
Congestive heart failure		
Damaged heart valves		
Daytime sleepiness		
Depression		
Diabetes		
Type I or Type II		

	YES	NO
Eating Disorder		
Epilepsy		
Excessive urination		
Gastrointestinal disease		
GE Reflux (heartburn)		
Glaucoma		
Heart Attack		
Heart Murmur		
Hepatitis, jaundice or liver disease		
High Blood Pressure		
Kidney Problems		
Low Blood Pressure		
Malnutrition		
Neurological disorders		
Night Sweats		
Osteoporosis		
Other mental health condition		
Specify:		
Other vision or hearing problem		
Overweight		
Pacemaker		
Recurrent infections		
Type:		

	YES	NO
Seizures		
Severe Headaches		
Severe or rapid weight loss		
Sexually transmitted disease		
Sinus Trouble		
Sleep Disorder		
Specify:		
Snoring		
Stop breathing when sleeping		
Stroke		
Thyroid problems		
Tonsillitis		
Tuberculosis		
Ulcers / Colitis		
Other		

Do you have any disease, condition, or problem not listed above that you think I should know about? **YES** **NO**

Please explain:

Primary MEDICAL Insurance

Ins Company: _____

Subscriber: _____

Employer: _____

Subscriber's Date of Birth: _____

Subscriber's SS#: _____

Policy #: _____

Primary Dental Insurance:

Company: _____

Subscriber_____

Employer: _____

Subscriber's Date of Birth: _____

Subscriber's SS#:_____

Policy #: _____

Secondary Insurance: Medical or Dental

Company: _____

Subscriber:_____

Employer: _____

Subscriber's Date of Birth: _____

Subscriber's SS#:_____

Policy # _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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 this information for treating 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 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.

Signature of Patient/Legal Guardian:

Date:

E R I C K S O N &G I L L
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CONSENT TO PERFORM DENTISTRY

I hereby authorize and direct Drs. Erickson & Gill and/or dental auxiliaries of his/her choice, to perform the following dental procedures including the use of any necessary or advisable local anesthesia, radiographs or diagnostic aids.

A. Preventive hygiene treatment and fluoride application

B. Application of sealants

C. Treatment of diseased or injured teeth with restorations

D. Replacement of missing teeth with prosthesis

E. Removal of teeth

F. Treatment of diseased or injured oral tissues

G. Use of sedative drugs to control apprehension and/or disruptive behavior

H. Treatment of crooked teeth and/or oral development or growth abnormalities

I. Use of general anesthesia to accomplish the necessary treatment

I understand that there are risks involved in treatment and hereby acknowledge that these risks will be explained to me. I will have the opportunity to ask questions regarding the treatment and risks.

I will be advised that the success of the dental treatment to be provided will require the patient and/or guardian follow post operative instructions. I agree that the success of the treatment requires that all post operative instructions be followed and regular office visits be maintained.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures. I therefore authorize and request the performance of any additional procedures that are deemed necessary to oral health in the professional judgment of the dentist.

There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue. Lip or cheek biting may result in ulceration and infection of the mucosa. I also understand that there are rare potential risks, such as unfavorable reactions to medications, in respiratory and cardiovascular collapse that could result in coma or death. I understand and have been informed of the above risks and complications.

I agree to the use of local anesthesia and nitrous oxide/oxygen anesthesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention around the nose which disappears shortly after the procedure.

I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

I hereby state that I have read and understand this consent. All questions regarding procedures will be answered in a satisfactory manner.

I further understand this consent will remain in effect until such time that I choose to terminate it.

Patient Name: _____ Relationship to Patient (if not self): _____

Signature: _____ Date: _____

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GENERAL DENTISTRY | BRACES | IMPLANTS | TMD | HEADACHES | PERSONALIZED CARE

FINANCIAL ARRANGEMENTS

If you have any questions concerning financial arrangements, please ask for assistance. Patient portion is due in full at each appointment. For your convenience, we offer the following methods of payment:

• Cash/Money Order • Check (in state) • MasterCard /Visa • Outside Financing (ask for details)

____Initial: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service.

____Initial: I hereby authorize payment of dental benefits directly to the dentist or group, otherwise payable to me.

____Initial: I understand that my dental insurance carrier may pay less than the actual bill for service.

____Initial: I understand I am responsible for payment in full of all accounts and agree to be responsible for payment of services not paid in whole or in part by my insurance carrier.

____Initial: I understand that although the insurance claim will be filed as a courtesy to me, I am ultimately responsible for the payment of dental services.

____Initial: If the account is not paid in full and collection procedures begin, I understand that I am responsible for all additional fees incurred during the collection process.

____Initial: I agree to permit Erickson & Gill Dentistry and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

____Initial: I understand there is a mandatory 48-hours' notice for cancellation of appointment. There will be a charge of $50 per hour scheduled for missed appointments. I understand I am responsible for these charges if I fail to give proper notice of cancellation.

Patient Name: _____ Relationship to Patient (if not self): _____

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The attached Notice of Privacy Practices describes how the Erickson & Gill, P.A. owned dental offices and the individual members of its professional staff may use and disclose your medical information and how you get access to this information. Please review it carefully. If you have any questions about the notice, please contact our Privacy Office at (620) 326-5751.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A complete copy of the Facility's Notice of Privacy Practices is attached. By signing below, you acknowledge that you have received a copy of the Facility's Notice of Privacy Practices.

Signature: _____ Date: _____

Time: _____(A.M. /P.M.)

IF PATIENT IS A MINOR OR IMCOMPETENT: I hereby acknowledge that I have received a copy of the Facility's Notice of Privacy Practices on behalf of the patient.

Signature: _____ Date: _____

Time: _____(A.M. /P.M.)

Relationship to patient:_____

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HIPAA AUTHORIZATION FORM

Erickson and Gill Dentistry has taken measures to protect all of our patient's private dental and medical information. HIPAA (Health Insurance Privacy & Accountability Act) **DOES ALLOW** us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment (i.e. specialist), your insurance company, your pharmacy or hospital. We will not release any of your information to anyone unless you have provided the requested information below.

Please fill out the upper portion if you wish for anyone else to be able to contact our office on your behalf. OR if you would not like anyone to be able to contact us on your behalf please fill out of the lower portion.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, **am authorizing** the person / people listed below to obtain medical information about myself. I understand that Erickson and Gill Dentistry is not responsible for the information provided as long as it is given to a person that I have listed below.

****Date of Birth must be provided so that our office can verify that we are speaking to the correct person****

1. Name: _____ DOB: _____ Relationship to Patient: _____
2. Name: _____ DOB:_____ Relationship to Patient: _____
3. Name: _____ DOB:_____ Relationship to Patient: _____
4. Name: _____ DOB: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

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I, _____, **do not** authorize Erickson and Gill Dentistry to release **any** of my protected medical information to anyone other than the entities that are discussed in the Notice of privacy practices.

Patient Signature: _____ Date: _____