# AVON DENTAL GROUP, P.C.

# WELCOME!

**CONFIDENTIAL**

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

## Patient Information

*Please Print*

Legal Name_____ Home Telephone_____

Address_____ City_____ State_____ Zip Code_____

Employer _____ Work Telephone_____ Cell Phone Number _____

Social Security Number_____ Email Address _____

Date of Birth_____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Person Responsible for Payment_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip Code_____

Person to contact in case of emergency_____ Phone #_____

Whom may we thank for referring you to us?_____

## Dental Insurance Information

Name of Insured_____ Relationship to patient_____

Social Security Number_____ Date of Birth_____ Date employed_____

Name of Employer_____

Employer Address_____ Phone Number_____

Insurance Company_____ Insurance Phone Number_____

Insurance Address_____ City_____ State_____ Zip Code_____

Group Number _____ Subscriber Number_____ Effective Date_____

## Dental History

Name_____

Former Dentist_____ Date of last exam_____ Date of last x-rays_____

Reason for today's visit _____

How often do you brush your teeth? _____ How often do you floss?_____

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

Please check any of the following conditions that apply to you:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Jaw Pain
- ❑ Grinding of teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sores or growths in mouth
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when chewing
- ❑ Sensitivity to cold

AFFINITY Dental Management excellence together

# Patient Medical History

**Patient Name** _____ **Date of Birth** _____

**General Health**

1. I consider my general health to be -check one ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   If fair or poor, please describe: _____

Do you have or have you had any of the following? Please circle Y for yes or N for no.

2. High Risk for Bacterial Endocarditis
   a. Y N Artificial (prosthetic) heart valve**
   b. Y N Previous infective endocarditis (heart infection)**
   c. Y N Damaged valves in transplanted heart **
   d. Congenital heart disease (CHD):
      Y N Unrepaired cyanotic CHD, including shunts and conduits (blood bypassing the lungs) **
      Y N CHD, repaired (completely) in last 6 months**
      Y N CHD, repaired with residual defects**

*** Except for these conditions, antibiotic prophylaxis is no longer recommended for any other form of heart disease or CHD*

3. Cardiovascular Diseases
   a. Y N Heart Disease Please describe: _____
   b. Y N Heart valve problem/Heart Murmur/Mitral Valve Prolapse/Rheumatic fever
   c. Y N Heart arrhythmia
   d. Y N Pacemaker
   e. Y N Abnormal Blood Pressure High or low? _____ Typical blood pressure: _____
   f. Y N Heart attack Date: _____ Please describe: _____
   g. Y N Stent or bypass
   h. Y N Stroke Date: _____ Please describe: _____
   i. Y N I take aspirin daily Dose: _____
   j. Y N I take blood thinners daily (e.g., Coumadin/warfarin, Eliquis, Pradaxa, Xarelto, Plavix, etc.) Name of medication: _____

4. Respiratory Diseases
   a. Y N Tuberculosis
   b. Y N Lung disease, COPD, pneumonia, bronchitis Please describe: _____
   c. Y N Asthma, reactive airway disease, wheezing, or breathing problems
   d. Y N Sinus trouble/sinus surgery
   e. Y N Hay fever

5. Diabetes/Endocrine Diseases
   a. Y N Diabetes Type _____ My last "A1c" was _____ Date: _____
   b. Y N Take insulin/medications for diabetes If so, please provide name: _____
   c. Y N I measure my blood sugar How often: _____
   d. Y N Excessive urination and/or thirst
   e. Y N Thyroid disease or pituitary disease Please describe: _____

6. Stomach, Liver and Kidney Diseases
   a. Y N Ulcers/GERD (acid reflux)/intestinal problems
   b. Y N I take antacids like Pepcid, Zantac, Prilosec, etc.
   c. Y N Bulimia
   d. Y N Liver disease, jaundice, or hepatitis Type _____
   e. Y N Kidney Disease
   f. Y N Dialysis If so, what days? _____

7. Other Diseases and Conditions
   a. Y N Arthritis, please indicate type (osteoarthritis, rheumatoid, etc.): _____
   b. Y N Implants/artificial joints: hip, knee _____ Other _____
   c. Y N Trauma – head, neck or body? Please describe: _____
   d. Y N Organ transplant/donor Which organ? _____ When? _____
   e. Y N Cancer, tumor or malignancy Please describe: _____
   f. Y N Chemotherapy/radiation therapy
   g. Y N Anemia, sickle cell disease/trait, or blood disorder
   h. Y N Hemophilia, bruising easily, or excessive bleeding
   i. Y N Herpes/aphthous ulcers
   j. Y N Sexually transmitted/venereal diseases
   k. Y N HIV/AIDS
   l. Y N Immune suppressed disorder Please describe: _____
   m. Y N Glaucoma

**Doctor Notes Only:**

**Patient Name** _____ **Date of Birth** _____

n. Y N Hearing loss/hearing aids
o. Y N Recurrent or frequent headaches/migraines Please describe: _____
p. Y N Fainting, loss of consciousness or dizziness Please describe: _____
q. Y N Cerebral palsy, brain injury, epilepsy, or convulsions/seizures
r. Y N History of drug addiction or alcohol addiction
s. Y N Behavioral, emotional, communication, or psychiatric problems/treatment Please describe: _____
Treatment received medications: _____
t. Y N Dementia, Alzheimer's disease or other memory disease Please describe: _____
Treatment received medications: _____
u. Y N Have you taken opiates/narcotics to manage pain? Last taken date: _____
v. Y N Do you smoke/vape/use chewing tobacco? If yes, how much per day? _____ How many years? _____
w. Y N Do you consume alcohol? If yes, how much per day? _____ How many years? _____
x. Y N Do you use marijuana? If yes, how much per day? _____ How many years? _____
y. Y N Do you use recreational drugs? If yes, how much per day? _____ How many years? _____
z. Y N Do you take or have you ever taken bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) or other "anti-resorptive" drugs for Osteoporosis or any other condition? If so, do you receive them by IV or take them orally? _____

8. Y N Have you had any major surgeries or hospitalizations?
Year _____ Type of operation _____
Year _____ Type of operation _____
Year _____ Type of operation _____
Year _____ Type of operation _____

9. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

10. Women:
a. Y N Are you taking birth control medication? Which one: _____
b. Y N Are you or could you be pregnant? Due date: _____
c. Y N Are you nursing? Baby's birth date: _____

11. Are you allergic to any of the following?
a. Y N Local Anesthetics (i.e., Novocain, Lidocaine)
b. Y N Penicillin
c. Y N Other antibiotics _____
d. Y N Latex
e. Y N Aspirin (Excedrin, Bayer, etc.)
f. Y N Ibuprofen (Advil, Motrin, etc.)
g. Y N Acetaminophen (Tylenol, etc.)
h. Y N Sulfa Drugs/Sulfites/Sulfides
i. Y N Codeine
j. Y N Metals, Plastics
k. Y N Dyes or artificial coloring
l. Y N Iodine, iodine-based antiseptics, shellfish, or radiologic dyes Which one? _____
m. Y N Pine nuts, colophony, peanuts, other nuts? Which one? _____
n. Y N Other Medications. Which ones? _____
o. Y N Other Allergies. Which ones? _____

12. Please list all medications or supplements you are currently taking (or submit list of medications):
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

13. Physician's Name _____ Phone _____ Fax _____
Address _____ Date last seen by Physician? _____

Initial medical/dental reviewed by:

X _____ _____
*Doctor's Signature* *Date*

*(If patient is a minor, guardian's signature is required)*

X _____ _____
*Patient's Signature* *Date*

Periodic medical/dental reviewed by:

X _____ _____ ☐ *No changes to above* X _____ _____
*Doctor's Signature* *Date* *Patient's Signature* *Date*

X _____ _____ ☐ *No changes to above* X _____ _____
*Doctor's Signature* *Date* *Patient's Signature* *Date*

X _____ _____ ☐ *No changes to above* X _____ _____
*Doctor's Signature* *Date* *Patient's Signature* *Date*

**Doctor Notes Only:**

## Authorization to Disclose Health Information to Family Members and Friends

Patient Name _____Date of Birth_____/_____/_____

I hereby authorize Avon Dental Group ("ADG") to release my patient health information as described below:

| Name of person | Relationship |
|---|---|
| | |
| | |
| | |

*Protected Health Information* ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in ADG's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that ADG may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

**(Check One) I DO____DO NOT____ GIVE PERMISSION** to Avon Dental Group, to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members. HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of ADG. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, ADG will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

Signature of Patient or Personal Representative (i.e. Guardian) Relationship of Personal Representative to Patient

Date of Authorization_____