Smyrna Dental and Implant Center

Health History & Clinical Review

To Our Patients: We care about you! Although we are primarily treating the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please read and complete each of the following sections. The better we communicate, the better we can care for you. And **thank you** for answering the following questions. Your answers are for our records only and will be considered confidential. It will enable our office to be more effective in meeting your needs. If you have any questions at anytime, please ask us. We will be happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the COG and the ADA. If the patient is a minor under the age of 18 years, a Parent/Guardian **MUST** complete and sign the final section. The Guarantor **MUST** be 18 years or older. **Providing your email address is giving consent to communicate electronically. Don't worry, we don't believe in SPAM!!**

Patient Information

Title: Mr. ( ) Mrs. ( ) Ms. ( ) Dr. ( ) Today's Date: _____

Name: (first, middle, last) _____

Social Security # _____ Email _____

Sex: Male ( ) Female ( )DOB: _____Age: _____

Home address: _____ City/State/Zip: _____

Home Phone#: _____ Cell#: _____ Work#: _____

Dental Insurance Company: _____ Subscriber:_____

Employer:_____ Job Title:_____

Emergency Contact

Name: _____ Phone #: _____

Clinical Review

Is this visit related to an accident? _____ Automobile ( ) Work related ( ) Other ( )

How did you hear about our office? _____

Have you ever been a patient of our practice? Yes ( ) No ( )

When was your last dental visit? _____

How many times a week do you brush? _____ How many times a day do you floss? _____

Is there anything you would like to change about your teeth? _____

What is most important to you in a dentist? _____

Have you ever had heavy bleeding after dental treatment? _____

Have you ever had a bad experience in the dental office? _____

Are your teeth sensitive to: Sweet ( ) Cold ( ) Heat ( ) Pressure ( )

Have you had dental x-rays taken within the last five years? _____

Medical History

Are you in good health?	Yes ( ) No ( )	Smoke or use tobacco?	Yes ( ) No ( )
Currently under the care of a physician?	Yes ( ) No ( )	Drink coffee, tea, or cola?	Yes ( ) No ( )
Currently in any pain?	Yes ( ) No ( )	Nervousness?	Yes ( ) No ( )
Recently hospitalized?	Yes ( ) No ( )	Have sores in your mouth?	Yes ( ) No ( )
Experience anxiety in dental office?	Yes ( ) No ( )	Have bad breath?	Yes ( ) No ( )
Pain/Swelling/Bleeding gums?	Yes ( ) No ( )	Food catching between teeth?	Yes ( ) No ( )
Have you had Periodontal surgery?	Yes ( ) No ( )	Have you had Oral Surgery?	Yes ( ) No ( )
Had TMJ or jaw clicking?	Yes ( ) No ( )	Noticed loose teeth?	Yes ( ) No ( )
Clench/grind your teeth?	Yes ( ) No ( )	Are you pregnant or nursing?	Yes ( ) No ( )

Medical History

Any recent changes in your general health? Yes ( ) No ( )

Aids/HIV/STD?	Yes ( ) No ( )	Epilepsy/Seizures?	Yes ( ) No ( )
Allergies/Hay Fever?	Yes ( ) No ( )	Headaches?	Yes ( ) No ( )
Anemia?	Yes ( ) No ( )	Heart attack ?	Yes ( ) No ( )
Artificial Bones/Joints?	Yes ( ) No ( )	Heart-Bacterial Endocarditic?	Yes ( ) No ( )
Asthma/Difficulty Breathing?	Yes ( ) No ( )	Heart/ Valve Replacement?	Yes ( ) No ( )
Back or Neck Problems?	Yes ( ) No ( )	Heart-Pace Maker?	Yes ( ) No ( )
Blood Pressure-High/low?	Yes ( ) No ( )	Hemophilia?	Yes ( ) No ( )
Blood Transfusion?	Yes ( ) No ( )	Hepatitis A or B?	Yes ( ) No ( )
Cancer/Chemotherapy?	Yes ( ) No ( )	Kidney/Liver/ulcer problems?	Yes ( ) No ( )
Diabetes?	Yes ( ) No ( )	Rheumatic or Scarlet Fever?	Yes ( ) No ( )
Dizziness or Fainting?	Yes ( ) No ( )	Sickle Cell Disease?	Yes ( ) No ( )
Drug/Alcohol Abuse?	Yes ( ) No ( )	Sinus Trouble?	Yes ( ) No ( )
Emphysema?	Yes ( ) No ( )	Shingles or TB?	Yes ( ) No ( )

Please list any other medications conditions that aren't listed?

_____

_____

Is there a family history of …

Heart disease? Yes ( ) No ( ) Diabetes? Yes ( ) No ( ) Anesthetic problems? Yes ( ) No ( )

Medications

Are you currently taking any of the following?

Birth control pills? Yes ( ) No ( )
Anticoagulants? Yes ( ) No ( )
Aspirin? Yes ( ) No ( )
Coumadin? Yes ( ) No ( )
St. John's Wart? Yes ( ) No ( )
Vitamin E? Ginko Biloba, Plavix? Yes ( ) No ( )
Any natural/homeopathic meds? Yes ( ) No ( )
Bisphosphonates, bone density meds? Yes ( ) No ( )
Any other medications not listed? _____

Allergies

I have no known allergies ( )

Latex? Yes ( ) No ( )
Aspirin? Yes ( ) No ( )
Nitrous Oxide? Yes ( ) No ( )
Local anesthetic? Yes ( ) No ( )
Penicillin? Yes ( ) No ( )
Erythromycin? Yes ( ) No ( )
Tetracycline? Yes ( ) No ( )
Other antibiotics? Yes ( ) No ( )
Ibuprofen/Motrin? Yes ( ) No ( )
Codeine or Percocet/Percodan? Yes ( ) No ( )
Darvon? Yes ( ) No ( )
Demerol? Yes ( ) No ( )
Sulfa drugs? Yes ( ) No ( )
Sodium pentothal/valium? Yes ( ) No ( )
Sulfites? Yes ( ) No ( )
Any other allergies not listed? _____

Signature _____ **Print Name _____**

Date _____

Smyrna Dental and Implant Center

David A. Lamothe, DDS

Financial Information

Thank you for choosing our office for your dental needs. We will be happy to work with you in planning your treatment to fit your budget. We do ask that you pay in full for the treatment on the day the treatment is performed. Our Financial Coordinator will be happy to give you an estimate of your patient portion before we perform services. If you should need extensive dental treatment, we gladly offer different payment options. (Care Credit, Visa, Mastercard, American Express, Cash, or Check) For our patients who have dental insurance, we are happy to accept the assignment of your insurance benefits directly to our office. Please be aware that your estimated portion will be due on the day of treatment, and we can never guarantee an exact amount that your carrier will pay. You will be financially responsible for any remaining amount not paid by your insurance carrier. Also if a claim is not paid within 30 days by your insurance company the balance will be the patient's responsibility. **Initial** _____

HIPAA CONSENT

I give Smyrna Dental and Implant Center my consent to use or disclose my protected health information to carry out my treatment, to obtain information from insurance companies, and health care operations like quality reviews. I have been informed that I may review the practice Notice of Privacy Policies before signing this consent.

I understand that this practice holds the right to request restrictions on how my protected health information is used. However, I also understand that the practice is not required to agree to my request. If the practice agrees to my privacy restrictions, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already disclosed. **Initial** _____

Broken Appointment Policy

If you have an avoidable conflict and cannot give 24 hr notice to change the appointment, there will be no charge for the first time this happens. The second, subsequent cancellation for the same appointment will incur a fee of 1/2 the scheduled amount of treatment. A third subsequent cancellation of the same appointment will require prepayment of the entire fee prior to rescheduling and the fee forfeited if the appointment is not kept. 24-hour notice will give us time, usually, to fill in the appointment and there will be no broken appt fee. **Initial** _____

Patient/Guardian _____ Date_____

(Patient or Parent if Minor)