EXETER FAMILY DENTAL CARE

ADULT PATIENT INFORMATION

Today's Date: _____ Date of Birth: _____ Social Security #: _____

First Name: _____ Last Name: _____ Nickname: _____

Home Address: _____

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

E-mail Address: _____

Best to contact at (please circle): Home Work Cell

Best to confirm appointment via (please circle all that apply): Phone E-mail Text Message

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN ABOVE)

Name Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Address if different from above: _____

DENTAL INSURANCE INFORMATION (if none leave blank)

Subscriber Name: _____ Subscriber's Date of Birth: _____

Subscriber ID Number: _____ Group Number: _____

Employer: _____ Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone: _____

SECONDARY INSURANCE INFORMATION (if none leave blank)

Subscriber Name: _____ Subscriber's Date of Birth: _____

Subscriber ID Number: _____ Group Number: _____

Employer: _____ Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone: _____

For whom can we thank for referring you? _____

EXETER FAMILY DENTAL CARE **Patient Name:** _____ **Date of Birth:** _____

MEDICAL HISTORY

Over the past few years, medical research has proven there is a direct link between the oral cavity and the rest of the body. Many systemic medical conditions can affect the health of the hard and soft tissues in your mouth. In order for our office to provide you with the most comprehensive oral care we request that you provide us with a thorough and complete medical history.

Primary Care Physician's Name: _____ Primary Care Physician's Phone Number: _____

Pharmacy name, address and phone number: _____

Approximate date of last routine physical examination: _____

	Yes	No	DK (Don't Know)
Have you ever been hospitalized for a serious medical condition or surgery?	❑	❑	❑
If yes, please explain and date(s): _____			
Are you taking any prescription medications?	❑	❑	❑
If yes, please list names: _____			
Do you take any over the counter medications on a daily basis?	❑	❑	❑
If yes, please list names: _____			
Do you take any vitamin, mineral or herbal supplements?	❑	❑	❑
If yes, Please list: _____			
Has a physician or previous dentist ever recommended that you take antibiotics prior to dental treatment?	❑	❑	❑

Allergies: Are you allergic to any of the following (To all yes responses, please indicate type of reaction):

	Yes	No	DK		Yes	No	DK
Local Anesthetic	❑	❑	❑	Metals	❑	❑	❑
Aspirin	❑	❑	❑	Latex (Rubber)	❑	❑	❑
Penicillin	❑	❑	❑	Iodine	❑	❑	❑
Other Antibiotics	❑	❑	❑	Hay fever/Seasonal	❑	❑	❑
Barbiturates or sedatives	❑	❑	❑	Food	❑	❑	❑
Sulfa Drugs	❑	❑	❑	Other	❑	❑	❑

Cardiovascular: Do you currently, or have you ever had any of the following conditions:

	Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve	❑	❑	❑	Congestive Heart Failure	❑	❑	❑
Previous Infective Endocarditis	❑	❑	❑	Cardiovascular Disease	❑	❑	❑
Damaged valves in a transplanted heart	❑	❑	❑	Angina (Chest Pain)	❑	❑	❑
Congenital heart disease or defects(CHD)	❑	❑	❑	**If yes**, do you wear a Nitroglycerin Patch?	❑	❑	❑
If yes: Unrepaired, cyanotic CHD	❑	❑	❑	Heart Attack	❑	❑	❑
Repaired (completely) in last 6 months	❑	❑	❑	**If yes,** date(s): _____			
Repaired CHD with residual defects	❑	❑	❑	High Blood Pressure	❑	❑	❑
Heart Shunt	❑	❑	❑	Low Blood Pressure	❑	❑	❑
Mitral Valve Prolapse	❑	❑	❑	Arteriosclerosis	❑	❑	❑
Pacemaker	❑	❑	❑	Heart Stent(s)	❑	❑	❑
Irregular Heartbeat	❑	❑	❑	Stroke	❑	❑	❑
Are you under the care of a Cardiologist	❑	❑	❑	**If yes**, date(s): _____			

If yes, Cardiologist's name and phone number: _____

Hematology: Do you currently or have you ever had any of the following conditions:

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Abnormal bleeding or wound healing	❑	❑	❑	Anemia	❑	❑	❑	Bruise Easily	❑	❑	❑
AIDS or HIV Infection	❑	❑	❑	Hemophilia	❑	❑	❑	Other Bleeding Disorder	❑	❑	❑
Blood Transfusion	❑	❑	❑								

If yes, date(s): _____

Cancer: Do you currently, or have you ever had any of the following:

	Yes	No	DK
Cancer	❑	❑	❑

If yes, type(s) or location(s) and dates diagnosed: _____

Treatment: _____

Are you (please circle): Currently undergoing treatment **or** In remission

Oncologist Name and Phone Number: _____

Chemotherapy Treatment	❑	❑	❑
If yes, do you have an implanted port or shunt	❑	❑	❑
Radiation Therapy	❑	❑	❑

Glands: Do you currently or have you ever had any of the following:

	Yes	No	DK
Hyperthyroid	❑	❑	❑
Hypothyroid	❑	❑	❑
Diabetes	❑	❑	❑

Pulmonary: Do you currently or have you ever had any of the following conditions:

	Yes	No	DK
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
COPD	❑	❑	❑
Tuberculosis	❑	❑	❑
Emphysema	❑	❑	❑
Pneumonia	❑	❑	❑
Sinus Trouble	❑	❑	❑
Difficulty Breathing or Shortness of breath	❑	❑	❑
Persistent Cough	❑	❑	❑

Bones, Muscles, and Joints: Do you currently or have you ever had any of the following conditions:

	Yes	No	DK
Orthopedic Total Joint Replacement (Hip, Knee, etc.)	❑	❑	❑
Arthritis	❑	❑	❑
Back/Spinal pain or injury	❑	❑	❑
Osteoporosis	❑	❑	❑

If yes, joint(s) involved and date(s): _____

Neurological/Mental Health: Do you currently or have you ever had any of the following conditions:

	Yes	No	DK
Frequent Headaches /Migraines	❑	❑	❑
Alzheimer 's disease	❑	❑	❑
Post Traumatic Stress Disorder	❑	❑	❑
Mental Health Disorders	❑	❑	❑
Sleep Disorders	❑	❑	❑
Dementia	❑	❑	❑
Fainting Spells or seizures	❑	❑	❑
Epilepsy	❑	❑	❑
Fibromyalgia	❑	❑	❑
Other Neurological Disorders	❑	❑	❑

If yes, please list: _____

If yes, please list: _____

Immune System: Do you currently or have you ever had any of the following:

	Yes	No	DK
Persistent swellings	❑	❑	❑
Organ Transplant(s)	❑	❑	❑
Recurrent Infections	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Autoimmune Disease	❑	❑	❑
Night sweats	❑	❑	❑

If Yes. Date(s): _____

Genitourinary: Do you currently or have you ever had any of the following conditions:

	Yes	No	DK
Hepatitis B, C or D	❑	❑	❑
Excessive Urination	❑	❑	❑
Sexually Transmitted Disease(s)	❑	❑	❑
Jaundice	❑	❑	❑
Kidney Disease	❑	❑	❑
Liver Disease	❑	❑	❑
Kidney Dialysis	❑	❑	❑

Eyes and Ears: Do you currently or have you ever had any of the following:

	Yes	No	DK
Glaucoma	❑	❑	❑
Dry Eyes	❑	❑	❑
Wear glasses or contact lenses	❑	❑	❑
Frequent ear aches/infections	❑	❑	❑
Macular Degeneration	❑	❑	❑
Wear Hearing Aids	❑	❑	❑
Vertigo/Dizziness	❑	❑	❑

WOMEN ONLY:

	Yes	No	DK
Are you currently nursing	❑	❑	❑
Taking oral contraceptives	❑	❑	❑
Are you currently pregnant or trying to get pregnant	❑	❑	❑

	Yes	No	DK
Do you have any other medical condition not listed above?	❑	❑	❑

If Yes, please list:_____

I certify that the information provided on this form is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on this information for treating me. I acknowledge that my questions, if any, about anything above have been satisfactorily answered. I will not hold the dentist or staff responsible for any action they take or do not take because of errors or omissions that I may have made in completing this form.

Patient Signature:_____ **Date:**_____

EXETER FAMILY DENTAL CARE

ADULT DENTAL HISTORY FORM

Patient Name: _____ Patient Date of Birth: _____

Approximate Date of last dental cleaning: _____

Approximate Date of last dental x-rays: _____

How often do you brush your teeth? _____

How often do you floss? _____

	Yes	No
Are you currently experiencing any pain or discomfort?	❑	❑
Do your gums bleed when you brush or floss?	❑	❑
Are your teeth sensitive to hot or cold?	❑	❑
Do you have pain or sensitivity when you bite or chew?	❑	❑
Does food or floss catch between your teeth?	❑	❑
Is your mouth dry?	❑	❑
Do you normally have a sour, salty, metallic or other strange taste in your mouth?	❑	❑
Is your home water supply fluoridated?	❑	❑
Do you drink mostly bottled and or filtered water?	❑	❑
Do you have earaches or neck pains?	❑	❑
Do you have any clicking, popping or discomfort in your jaw?	❑	❑
Do you clench or grind your teeth?	❑	❑
Do you frequently develop sores or ulcers in or around your mouth?	❑	❑
Do you wear dentures or partial dentures?	❑	❑
Do you participate in sports or recreational activities?	❑	❑
Have you ever had braces or orthodontic treatment?	❑	❑
Do you use any prescription rinses, toothpastes or other oral products?	❑	❑
Have you had any periodontal (gum) treatments or surgeries?	❑	❑
Do you drink alcohol?	❑	❑

Do you drink soda, sweetened ice tea or sports drinks (diet or regular)? **If yes, frequency?** _____

Do you drink citrus juice? **If yes, frequency?** _____

Have you in the past, or do you currently smoke, vape or chew tobacco? **If yes, type, frequency and # of years**:

_____

Do you use controlled substances or recreational drugs? **If yes, type and frequency:**

_____

Have you ever had a serious injury to your head, neck or mouth? **If yes, what and when?**

_____

Is there anything you don't like or would like to change about your smile? **If yes, please comment:**

_____

EXETER FAMILY DENTAL CARE

HIPPA Patient Privacy Policy Consent and Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Exeter Family Dental Care, our staff and our business associates for treatment, payment and health care operations. A more detailed description of uses and disclosures for these purposes are documented in our Notice of Privacy Practices ("Notice") as required by the Health Insurance Portability and Accountability ACT (HIPPA). You have the right to review and obtain a copy of our "Notice" prior to signing this consent and at anytime thereafter. The terms of the "Notice" may change. If the terms do change, you may obtain a revised notice by simply contacting Exeter Family Dental Care and requesting a revised copy either by phone (603)772-3351, via mail at Exeter Family Dental Care 193 High Street, Exeter New Hampshire 03833 or via email at exeterfamilydentalcare@comcast.net. We will also post any revisions to the "Notice" on our website: exeterfamilydentalcare.com.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations in writing. Forms are available upon request. We are not required to agree to your requested restrictions except in the case where the disclosure is to a health plan for the purposes of carrying out payment. If we agree to restrictions, they are binding on us. Under law, we have the right to refuse to treat you should you choose to refuse to disclose certain Protected Health Information (PHI).

This form will also serve as acknowledgment of receipt of our Notice of Privacy Practices or to document its good faith effort to obtain that acknowledgement.

You have the right to refuse to sign this acknowledgment.

I have reviewed, understand and agree to the content of the Exeter Family Dental Care Notice of Privacy Practices.

Signature:_____ Date:_____

Please specify the exact reason why patient chose not to sign the consent/acknowledgement of Notice of Privacy Practices

_____

_____

EXETER FAMILY DENTAL CARE

HIPPA Consent to Share Dental/Financial Information

As a patient in our practice you have signed or refused to sign our HIPPA Notice of Information Practices for sharing protected health information with our business associates and other health care professionals necessary for treatment and diagnosis. HIPPA rules and regulations prevent us from sharing dental, medical, financial or any other identifiable information (Protected Health Information) about you with other persons including family members and spouses without your consent.

The form below allows you to give our office staff permission to discuss all aspects of your dental, medical and financial history with others if you determine it to be necessary. Please note that patients 18 years of age are considered adults under HIPPA and we are not allowed to share information with their parents (even if financially responsible) without the patient's permission.

I hereby give Exeter Family Dental Care my permission to discuss all aspects of your dental treatment, medical and financial history with the individuals listed below.

Please check all that apply and list their names:

◯ Spouse _____

◯ Daughter _____

◯ Mother _____

◯ Son _____

◯ Father _____

◯ Other (Please Specify Relationship) _____

◯ I **DO NOT** give my permission to share with any other individual

Notes: _____

_____

Print Name: _____

Signature: _____

Date: _____