Scandia Family Dental PA

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Welcome to Scandia Family Dental

Health History

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

If you do not know the answer to the written questions please type "NA".

Date/Estimation of last Healthcare exam: * _____

Healthcare Clinic Name and Phone number:

Previous Dentist Name and Phone Number: *

Date of most recent dental exam and dental x-rays: * _____

For the following Questions please answer Yes or No, providing additional information as necessary to the best of your ability. Your answers are for our Records only and will be confidential.

Please note that during your Initial Visit with us you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Have you had any changes in your health in the last 2 years? * ◯ Yes ◯ No

If yes, What was the nature of the treatment or visit?

Are you currently recieving care by a Physician? * ◯ Yes ◯ No

If yes, What is the nature?

If receiving care currently by MULTIPLE Physicians please provide the Clinic name/s and Phone number/s:

Have you had any Surgical Operation of any kind? * ◯ Yes ◯ No

If yes, Please describe using the date of treatment/s also:

Have you been advised by a Physician of the need for any type of surgery or treatment? * ◯ Yes ◯ No

If yes, Please explain:

Have you ever had an ALLERGIC reaction of any kind:
(If yes to any of the following please explain in the space provided below) *

- ☐ Local Anesthetics or Epinephrine
- ☐ Penicillin or other Antibiotics
- ☐ Aspirin, Ibuprofen or Tylenol
- ☐ Codeine, Valium, Hydrocodone, Oxycodone or other Sedatives
- ☐ Latex or Metals
- ☐ Other
- ☐ None

Please explain Reaction, and list the name/s of Medication: _____

Are you currently taking any PRESCRIPTION medications at this time? * ○ Yes ○ No

PRESCRIPTION medications including dosages: _____

Are you currently taking any Over the Counter (OTC) medications at this time? *

- ○ No, I am not currently taking any Over the Counter (OTC) medications.
- ○ Yes, currently taking Over the Counter (OTC) medications and will list in the space provided below.
- ○ Yes, I have/will obtain a list of current Over the Counter (OTC) medications and will bring with me to my dental appointment.

Over the Counter medications: _____

Are you currently taking any Vitamins/Herbal/Supplements of any kind? *

- ○ No, I am not currently taking any Vitamins/Herbal/Supplements
- ○ Yes, currently taking Vitamins/Herbal/Supplements and will list in the space provided below.
- ○ Yes, I have/will obtain a list of current Vitamins/Herbal/Supplements and will bring with me to my dental appointment.

Vitamins/Herbal/Supplements, what is the purpose?: _____

Blood Pressure

What is your normal Blood Pressure? _____

Do you consume Caffeine? Approximate daily intake? * _____

Do you wear Contact Lenses at any time? * ○ Yes ○ No

For Women:
Are you Pregnant at this time? ○ Yes ○ No

If yes, what is your anticipated delivery date? _____
Are you planning a pregnancy in the near future? ○ Yes ○ No

Are you a nursing mother? ○ Yes ○ No

Are you taking Birth Control pills? If yes, What is the name? _____

Tobacco, Alcohol, Drugs

Do you currently use Tobacco products? * ○ Yes ○ No

If yes, please approximate the daily intake? _____

Do you consume Alcohol? * ○ Yes ○ No

If yes, approximately how many beverages per week? _____

Do you use any other Mood Altering drugs other than those previously listed currently; or have you in the past? * ○ Yes ○ No

If yes, What did you use? How much and how often?

_____

_____

_____

Weight and Diet considerations

Weight: * _____

Sugar in your diet? *

○ None ○ Slight ○ Moderate ○ High

ARE YOU SUPPOSED TO TAKE PRE-MEDICATION BEFORE DENTAL TREATMENT --------YES ---------NO

Have you ever taken any prescription drugs such as fen-phen for weight loss? * ○ Yes ○ No

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end? * ○ Yes ○ No

Is there anything you would like to discuss with the doctor alone? * ○ Yes ○ No

Do you have; have you had; or been treated for any of the following?

Have you/family had anesthesia related problems? * ○ Yes ○ No

Panic Attack, Phobia, Extreme Nervousness? * ○ Yes ○ No

Abnormal Bleeding from a cut? Blood Transfusion? * ○ Yes ○ No

Unintentional Weight Loss/Gain * ○ Yes ○ No

Chronic Diarrhea * ○ Yes ○ No

Heart Surgery, Congenital heart disease, Family History of Heart Issues * ○ Yes ○ No

Diabetes: A1c Level:

Previous Bacterial Endocarditis * ○ Yes ○ No

HEART STENT ? * ○ Yes ○ No

If yes, please provide the date the stent was placed. Joint Replacement? * ○ Yes ○ No

If yes, when was it replaced. _____

Sore/Enlarged Lymph Nodes * ○ Yes ○ No

Previous Biopsies * ○ Yes ○ No

Renal Dialysis * ○ Yes ○ No

Slow-Healing Mouth Sores * ○ Yes ○ No

Recurrent Illnesses * ○ Yes ○ No

- ☐ Anemia - Sickle Cell
- ☐ Blood Disordor
- ☐ Cancer: Leukemia
- ☐ Disease: Diabetes
- ☐ Disease: Crohns
- ☐ Enzyme Deficiency
- ☐ Glaucoma
- ☐ Heart: Murmur
- ☐ Heart:ArtificialValv
- ☐ HIV / AIDS / ARC
- ☐ Liver: Jaundice
- ☐ NO Epinephrine
- ☐ Resp: Tuberculosis
- ☐ Respiratory: Asthma
- ☐ Stomach Problems
- ☐ Venereal Disease
- ☐ Anorexia, Bulimia
- ☐ Blood Thinners
- ☐ Cancer: Tumors
- ☐ Disease: Heart
- ☐ Dizziness
- ☐ Epilepsy - Seizures
- ☐ Head Injuries
- ☐ Heart: Pacemaker
- ☐ Heart:HighBloodPress
- ☐ Hydrocephalus
- ☐ Mental Disorders
- ☐ OTHER/ask
- ☐ Resp: Emphysema
- ☐ Rheumatism
- ☐ Stroke
- ☐ x Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Cancer: Chemo/Radiat
- ☐ Disease: Kidney
- ☐ does not metabolize
- ☐ Excessive Bleeding
- ☐ Heart: Attack
- ☐ Heart: Transplant
- ☐ Heart:LowBloodPress
- ☐ Kidney transplant
- ☐ Mental: Sev Depressi
- ☐ PRE MED
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Thyroid Condition
- ☐ Artificial Joints
- ☐ Cancer: Growths
- ☐ Chemical Dependency
- ☐ Disease: Liver
- ☐ Ear Infections
- ☐ Fainting/Dizziness
- ☐ Heart: Mitral Valve
- ☐ Heart: Tachycardia
- ☐ Heart:RheumaticFever
- ☐ Liver: Hepatitis
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Respiratory: COPD
- ☐ Sjogren's Syndrome
- ☐ Ulcers

Other Conditions

☐ ***I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.**

DOCTORS USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental Management considerations:

I certify that the information given above is true and complete to the best of my ability.

Signature _____ Date _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. This HIPAA authorization does not expire until revoked.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ * By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

I authorize Scandia Family Dental PA to share my information with

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

I certify that the information given above is true and complete to the best of my ability.

Signature _____ Date _____

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COVID-19 PANDEMIC- PATIENT DISCLOSURES

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

Do you have a fever or above normal temperature? * ○ Yes ○ No

Have you experienced shortness of breath or had trouble breathing? * ○ Yes ○ No

Do you have a dry cough? * ○ Yes ○ No

Do you have a runny nose, not attributed to allergies? * ○ Yes ○ No

Have you recently lost or had a reduction in your sense of smell? * ○ Yes ○ No

Do you have a sore throat? * ○ Yes ○ No

Have you been in contact with someone who has tested positive for COVID-19? * ○ Yes ○ No

Have you tested positive for COVID-19? * ○ Yes ○ No

Have you been tested for COVID-19 and are awaiting results? * ○ Yes ○ No

Have you traveled outside the United States by air or cruise ship in the past 14 days? * ○ Yes ○ No

Have you traveled within the United States by air, bus or train within the past 14 days? * ○ Yes ○ No

☐ * **I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.**

By signing this document, I acknowledge that the answers I have provided above are true, accurate and complete.

Signature _____ **Date** _____