Medical History

Name:____ Date:_____________

MEDICAL HISTORY

Please write your physicians information. Dr.______________ Specialty ____________ Phone #______________
Address___________________ Date of Last Visit ____________Purpose of Visit _______________

Have you ever been hospitalized or had a major operation? Discuss ____________________________ Yes No

Have you ever had a serious injury to your head or neck? Discuss______________________________ Yes No

Are you on a special diet? Discuss ____ Yes No

Are you taking any of the following medications?

___Fosamax ___Actonel ___Boniva ___Aredia ___Bonefos ___Didronel ___Zometa

List any medications you are currently taking. ____

Please check if: ___Pregnant/trying to/Suspect __Nursing __Taking Contraceptives __Menopause

Discuss: ____

Do you now have or have had any of the following? Please circle appropriate.

Are you immunizations Up-To-Date? __Yes __No

Yes No Heart Surgery
Yes No Heart Murmur
Yes No Heart conditions
Yes No Congenital Cardiac Lesions
Yes No Artificial Heart Valves
Yes No Mitral Valve Prolapse
Yes No Pacemaker
Yes No Rheumatic Fever
Yes No Scarlet Fever
Yes No Bacterial Endocarditis
Yes No Spinal Bifida
Yes No Angina (Stable or Unstable)
Yes No Heart Attack
Yes No Cardiac Arrhythmias
Yes No Congestive Heart Failure
Yes No Cholesterol
Yes No High Blood Pressure
Yes No Arthritis
Yes No Osteoporosis
Yes No Orthopedic Problems
Yes No Obstructive Pulmonary
Yes No Respiratory Disease
Yes No Asthma

Yes No Lung Problems
Yes No Tuberculosis
Yes No Pneumonia
Yes No Kidney Disease
Yes No Hemodialysis
Yes No Hepatitis A B C D E
Yes No Liver Disease (Cirrhosis)
Yes No Stomach Problems
Yes No Intestinal Problems
Yes No Ulcers
Yes No Anorexia
Yes No Bulimia Nervosa
Yes No Inflammatory Bowel Disease
Yes No Pseudomembranous Colitis
Yes No Venereal Disease
Yes No AIDS
Yes No HIV Positive
Yes No Genital Herpes
Yes No Gonorrhea
Yes No Syphilis
Yes No Diabetes
Yes No Hypoglycemia
Yes No Glaucoma
Yes No Eye Problems

Yes No Hearing Loss
Yes No Otitis
Yes No Adrenal Insufficiency
Yes No Hypothyroid
Yes No Hyperthyroid
Yes No ADD/ADHD
Yes No Measles
Yes No Drug Allergies
Yes No Anesthetic Allergies
Yes No Latex Allergies
Yes No Rubber Product Allergies
Yes No Bleeding problems
Yes No Von Willebrand Disease
Yes No Blood Disease_____
Yes No Circulatory Problems
Yes No Hemophilia
Yes No Anemia
Yes No Sickle Cell Anemia
Yes No Sickle Cell Trait
Yes No Blood Transfusion
Yes No Organ Transplant
Yes No Cancer _________
Yes No Thrombocytopenia
Yes No Lupus
Yes No Leukemia

Yes No Chemotherapy
Yes No Fibromyalgia
Glucose-6-Phosphatase Deficiency
Yes No Developmentally Delayed
Yes No Mental Retardation
Yes No Down syndrome
Yes No Syndrome________
Yes No Depression
Yes No Bipolar Disorder
Yes No Brain Injury/ Trauma
Yes No Cerebrospinal Fluid Shunts
Yes No Schizophrenia
Yes No Stroke
Yes No Convulsions
Yes No Epilepsy or Seizures
Yes No Fainting or Dizziness
Yes No Tumors or Growths
Yes No Anxiety
Yes No Psychiatric Care
Yes No Alzheimer's disease
Yes No Drug Addiction/Usage
Yes No Alcohol Usage/ Alcoholism
Yes No Tobacco usage

Have your ever had any other serious illness not checked above? Discuss_______________________________

Do you wish to talk to the dentist privately about any problems?____

Patient Signature ________________ Date ________ Dentist Signature_______________ ASA I II III IV

DENTAL TREATMENT CONSENT FORM

Patient Name ______________________________ Birthdate ______________________

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

1. WORK TO BE DONE

I understand that I am having the following work done: Dental Exam ___ Cleaning ___ Digital X-Rays ___ Fluoride ___ Fillings ___ Bridges ___ Crowns ___ Extractions ___ Laser Anesthetic ___ Sealants ___ Root Canals ___ Other ______________

Initials ____________

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initials ____________

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials ____________

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth ____________ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials ____________

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

Initials ____________

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial. constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

Initials ____________

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

Initials ____________

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition.

Initials ____________

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorize for my self or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

______________________________ ______________

Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ______________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Patient Information

Patient:____ DOB:______________
Last Name First Name Middle Name

Address:____

City:____________________ State:______ Zip Code:________ Sex: (Circle) Male Female

Mailing Address (if different): ____

Marital Status (Circle): Single Married Divorced Widowed Other S.S.N:______________

Home Phone #:______________ Work Phone #:______________ Cell Phone #:____________

Emergency Contact (Name): ______________________ Emergency Phone #:______________

E-mail address:____

Patient relationship to the responsible party (Circle): Self Spouse Child Other

Primary Care Physician:____________________________ Referred by:________________

Patient's Employer Information (Circle): Full-time Part-time Student School School:__________

Company:____________________________________ Phone #:____________________

Responsible (Insured/ Parent/ Guardian) Party Information

Responsible Party's Name:____________________________________ DOB:__________

Address:____

City:__________________________ State:______________ Zip Code: ____________

S.S.N: ________________________ Sex (Circle): Male Female

Home Phone #:______________ Work Phone #:______________ Cell Phone #:____________

Responsible Party's Employer Information:
Company: ____

Insurance Information

Primary Insurance Company: ____

Insurance Address: ____

Insurance I.D. or S.S.N:__________________ Subscriber's Name: ____________________

Patient Relationship to Subscriber (Circle): Self Spouse Child Other Subscriber's DOB: _________

Secondary Insurance Company:____

Insurance Address: ____

Insurance I.D. or S.S.N:__________________ Subscriber's Name: ____________________

Patient Relationship to Subscriber (Circle): Self Spouse Child Other Subscriber's DOB: _________

HIPAA Release of Information
AUTHORIZATION FORM

I, ___________________________________hereby authorize *Dental Odyssey* and its affiliates, its employees and agents, to release to *my current insurance carrier and/or my physician and/or my nursing facility* my personal health information maintained by *Dental Odyssey* (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number) **except** the following information about me:

__________________________________ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues *and consult with my physician and/or nursing facility*. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the date I cease being a patient-of-record of *Dental Odyssey*. I understand that I have a right to revoke this authorization by providing written notice to *Dental Odyssey*. However, this authorization may not be revoked if *Dental Odyssey*, its employees, or authorized agents have taken action in reliance on this authorization prior to receiving my written notice. I also understand that I have a right to a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for treatment, benefits, enrollment, payment, or coverage of services.

Patient's Name: ____

Patient Signature:____

Date:____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., power of attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: ______________________________________

Signature of Legal Representative: __________________________________

Date: ____

Name of Witness: ____

Signature of Witness: ____

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