Personal History
(Information will be held in strict confidence)
"Please Print"

Date:___________

Patient Name: ____
Parent's Name (if minor patient): ____
Address: ____
City: ________________________ State: ____________ Zip: ______________________
Sex: ____ Date of Birth ____/____/____ Social Security #:_____-____-____
Drivers License #:____
Day Phone: _______________________ Evening Phone: __________________________
Email Address:____

Employer: ______________________________ Occupation: _______________________

Emergency Contact (Name and Phone Number):
____

Referred By: ____
(Whom may we thank for referring you?)

Financially Responsible Individual
(If different than patient or if there is **Dental Insurance**)

Do you have dental insurance? Yes____ No____

Dental Insurance:______________________ID:_______________Group #:__________
Address:____

Responsible individual: _________________ Relation to Patient: _________________
Address:____
City: ____
Sex: _____ Date of Birth: _____/_____/_____ Social Security # ______/______/______

How will you be paying for today's services?

Credit Card ______ Check ________ Cash _______

Signature: ____

Medical History

Date of Last Dental Visit: ____
Name of Treating Dentist/Other Doctor: ____
Address: ____

DO YOU HAVE OR HAVE YOU EVER HAD (If unknown, please indicate unknown):

YES	NO		YES	NO	
____	____	Anemia	____	____	Kidney Disease
____	____	Asthma	____	____	Hepatitis A/B/C
____	____	Diabetes	____	____	Rheumatic Fever
____	____	Cancer	____	____	Thyroid Condition
____	____	High Blood Pressure	____	____	Tuberculosis
____	____	Radiation Treatment	____	____	Stroke or Heart Attack
____	____	Abnormal Heart Condition	**Allergies to any of the Following:**		
____	____	Do You Have a Pacemaker?	____	____	Penicillin
____	____	Abnormal Bleeding From a Cut?	____	____	Local Anesthetic
____	____	Surgery	____	____	Aspirin
____	____	Joint Surgery or Replacement	____	____	Latex
____	____	Are You Pregnant?	____	____	Codeine
____	____	Immune System Disorder/Disease	(Other Allergy Specify):______________________________		
____	____	Mental/Neural Condition	____	____	Any Contagious Diseases
____	____	Epilepsy/Fainting	____	____	Venereal Disease
____	____	Glaucoma/Vision	____	____	AIDS/HIV Positive
____	____	Alcohol/Other Addiction	____	____	Other (Please specify)___________________

Please list all medications you (the patient) are currently taking and for what:______________________________________
____
____

The following is to be completed by Patient or, if minor, patient's legal guardian:

I have read and understand this form and have answered all the questions to the best of my ability.

Patient's Signature:____ Date: ___________________
Legal Guardian's Signature: ____ Date: ___________________
(If patient is a minor/child) Relationship to Child/Minor: ____

Doctor's Signature: ____ Date: __________

Witness's/ Dental Assistant's Signature: _____________________________________ Date: __________

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
You May Refuse To Sign This Agreement

I, ____, have received a copy of this office's Notice of Privacy Practices.
(Please Print Name)
Signature: ____ Date: _______________________

<u>For Office Use Only</u>
We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgment
__ An emergency situation prevented us from obtaining acknowledgement
__ Other (Please Specify)____

EDUCATION FOR PATIENTS REGARDING OPIOID USE

It is not uncommon for a tooth to be uncomfortable or even exhibit a dull ache immediately after receiving root canal therapy. The amount of discomfort after is often related to the amount of discomfort prior to treatment and will usually subside within one week if not sooner, but can last up to two weeks in some cases. We recommend acetaminophen, ibuprofen, and naproxen to be the best choice for pain relief after root canal treatment. In the rare event your pain is not relieved using over the counter medications, the doctor may prescribe an opioid. The decision to take prescription opioids is your choice. Prescription opioids can be used to help more severe pain when recovering from root canal therapy or surgery. Medications are an important part of your treatment when necessary and you should work closely with our prescribing doctor to understand the risks and benefits of taking any medications, including opioids. Knowing your options for pain management is important. Opioid use can have a number of side effects such as:

- Nausea, vomiting or dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Itching and sweating
- Constipation
- Addiction
- Opioid overdose can cause slowed breathing and even be fatal

If you discuss all your pain management options and risks with your doctor and you decide taking prescribed opioids is the best choice for your pain management:

- Understand all the risks and side effects of opioids use (Additional resources can be found on the CDC and FDA websites www.fda.gov and www.cdc.gov).
- Always take the prescribed opioid as directed by your prescribing doctor and never take more than your doctor ordered, or more frequently than your prescribing doctor ordered.
- Never use another person’s prescription opioids or share, sell or trade your own prescription opioids.
- Do not take other medications or prescribed opioids from other doctors without informing them of any and all medications you are taking and any potential drug interactions.
- Report any and all medications and health issues to your prescribing doctors before taking opioids and bring the pill bottle with to any hospital or doctor’s visits.
- Report any addiction problem to your doctor.
- The prescribing doctor will prescribe an appropriate number of pills to manage your pain. If your medicine is lost or stolen or used up sooner than prescribed, your medication may not be replaced. If a refill is required, contact your doctor’s office during normal business hours. No refills will be provided on nights, holidays or weekends.
- Properly dispose of any unused prescription opioids.

Your doctor will consult the state Prescription Drug Monitoring Program (PDMP) before prescribing you opioids.

My signature below acknowledged I have read and understand the information provided to me and my questions have been answered.

Patient’s (or Legal Guardian’s) Signature Date