

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?                      Excellent                      Good                      Fair                      Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**                      YES NO                      YES NO

1. hospitalization for illness or injury \_\_\_\_\_
2. an allergic or bad reaction to any of the following:  
aspirin, ibuprofen, acetaminophen, codeine \_\_\_\_\_  
penicillin \_\_\_\_\_  
erythromycin \_\_\_\_\_  
tetracycline \_\_\_\_\_  
sulfa \_\_\_\_\_  
local anesthetic \_\_\_\_\_  
fluoride \_\_\_\_\_  
chlorhexidine (CHX) \_\_\_\_\_  
iodine \_\_\_\_\_  
metals (nickel, gold, silver, \_\_\_\_\_ )  
latex \_\_\_\_\_  
nuts \_\_\_\_\_  
fruit \_\_\_\_\_  
milk \_\_\_\_\_  
red dye \_\_\_\_\_  
other \_\_\_\_\_
3. heart problems, or cardiac stent within the last six months \_\_\_\_\_
4. history of infective endocarditis \_\_\_\_\_
5. artificial heart valve, repaired heart defect (PFO) \_\_\_\_\_
6. pacemaker or implantable defibrillator \_\_\_\_\_
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) \_\_\_\_\_
8. heart murmur, rheumatic or scarlet fever \_\_\_\_\_
9. high or low blood pressure \_\_\_\_\_
10. a stroke (taking blood thinners) \_\_\_\_\_
11. anemia or other blood disorder \_\_\_\_\_
12. prolonged bleeding due to a slight cut (or INR > 3.5) \_\_\_\_\_
13. pneumonia, emphysema, shortness of breath, sarcoidosis \_\_\_\_\_
14. chronic ear infections, tuberculosis, measles, chicken pox \_\_\_\_\_
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion) \_\_\_\_\_
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) \_\_\_\_\_
17. kidney disease \_\_\_\_\_
18. liver disease or jaundice \_\_\_\_\_
19. vertigo (e.g., "the room is spinning") \_\_\_\_\_
20. thyroid, parathyroid disease, or calcium deficiency \_\_\_\_\_
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) \_\_\_\_\_
22. high cholesterol or taking statin drugs \_\_\_\_\_
23. diabetes (HbA1c = \_\_\_\_\_ ) \_\_\_\_\_
24. stomach or duodenal ulcer \_\_\_\_\_
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) \_\_\_\_\_

26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) \_\_\_\_\_
27. arthritis or gout \_\_\_\_\_
28. autoimmune disease  
(e.g., rheumatoid arthritis, lupus, scleroderma) \_\_\_\_\_
29. glaucoma \_\_\_\_\_
30. contact lenses \_\_\_\_\_
31. head or neck injuries \_\_\_\_\_
32. epilepsy, convulsions (seizures) \_\_\_\_\_
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) \_\_\_\_\_
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) \_\_\_\_\_
35. any lumps or swelling in the mouth \_\_\_\_\_
36. hives, skin rash, hay fever \_\_\_\_\_
37. STI/STD/HPV \_\_\_\_\_
38. hepatitis (type \_\_\_\_\_ ) \_\_\_\_\_
39. HIV/AIDS \_\_\_\_\_
40. tumor, abnormal growth \_\_\_\_\_
41. radiation therapy \_\_\_\_\_
42. chemotherapy, immunosuppressive medication \_\_\_\_\_
43. difficulties with stress management \_\_\_\_\_
44. psychiatric treatment, antidepressants, mood stabilizing medications \_\_\_\_\_
45. concentration problems or ADD/ADHD \_\_\_\_\_
46. alcohol/recreational drug use \_\_\_\_\_

## ARE YOU:

47. presently being treated for any other illness \_\_\_\_\_
48. aware of a change in your health in the last 24 hours  
(e.g., fever, chills, new cough, or diarrhea) \_\_\_\_\_
49. taking medication for weight management \_\_\_\_\_
50. taking dietary supplements, vitamins, and/or probiotics \_\_\_\_\_
51. often exhausted or fatigued \_\_\_\_\_
52. experiencing frequent headaches or chronic pain \_\_\_\_\_
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) \_\_\_\_\_
54. considered a touchy/sensitive person \_\_\_\_\_
55. often unhappy or depressed \_\_\_\_\_
56. taking birth control pills \_\_\_\_\_
57. currently pregnant \_\_\_\_\_
58. diagnosed with a prostate disorder \_\_\_\_\_

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) \_\_\_\_\_

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Referred by \_\_\_\_\_ How would you rate the condition of your mouth? Excellent Good Fair Poor  
Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
I routinely see my dentist every 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

### PERSONAL HISTORY



YES NO

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_
2. Have you had an unfavorable dental experience? \_\_\_\_\_
3. Have you ever had complications from past dental treatment? \_\_\_\_\_
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? \_\_\_\_\_

### GUM AND BONE



YES NO

7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? \_\_\_\_\_
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? \_\_\_\_\_
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? \_\_\_\_\_
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? \_\_\_\_\_
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? \_\_\_\_\_
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? \_\_\_\_\_

### TOOTH STRUCTURE



YES NO

14. Have you had any cavities within the past 3 years? \_\_\_\_\_
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? \_\_\_\_\_
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
20. Do you frequently get food caught between any teeth? \_\_\_\_\_

### BITE AND JAW JOINT



YES NO

21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? \_\_\_\_\_
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? \_\_\_\_\_
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? \_\_\_\_\_
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? \_\_\_\_\_
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

### SMILE CHARACTERISTICS



YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? \_\_\_\_\_
34. Have you ever bleached (whitened) your teeth? \_\_\_\_\_
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT REGISTRATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN (US): \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Billing Address: \_\_\_\_\_ Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Preferred contact (please circle): Home / Cell / Work

Patient is:  Policy Holder  Responsible Party

### Responsible Party (if someone other than the patient):

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SSN (US): \_\_\_\_\_

Responsible party is also Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

### Primary Insurance Information:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured SSN: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group: \_\_\_\_\_

### Secondary Insurance Information:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured SSN: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group: \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# HIPAA OMNIBUS RULE

## PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

How do you want to be addressed when summoned from reception area:

First Name Only  Proper Surname  Other \_\_\_\_\_ SSN (US): \_\_\_\_\_

Please list any other parties who are actively involved in your health care and who can have access to your health information: (This includes step-parents, grandparents, and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize contact from this office to **confirm my appointments, treatment, and billing information** via:

- Cell Phone Confirmation  Email Confirmation
- Text Message to my Cell Phone  Work Phone Confirmation
- Home Phone Confirmation  Any of the Above

I authorize information about my health be conveyed via:

- Cell Phone Confirmation  Email Confirmation
- Text Message to my Cell Phone  Work Phone Confirmation
- Home Phone Confirmation  Any of the Above

I approve being contacted about **special services, events, fund raising efforts, or new health info** on behalf of this healthcare facility via:

- Phone Message  Text Message  Email  Any of the Above  Non of the Above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.**

\_\_\_\_\_  
Please print name of Patient

\_\_\_\_\_  
Please sign Patient / Guardian of Patient

\_\_\_\_\_  
Legal Representative / Guardian

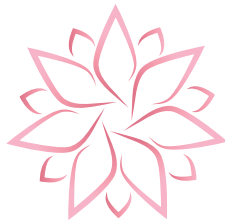
\_\_\_\_\_  
Relationship of Legal Representative / Guardian

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**OFFICE USE ONLY**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment  The patient refused to sign  Other (please describe) \_\_\_\_\_
- I could not communicate with the patient  The patient was unable to sign because \_\_\_\_\_

Signature of Privacy Officer \_\_\_\_\_



RADIANCE  
FAMILY & COSMETIC DENTISTRY

## DENTAL APPOINTMENT AGREEMENT

Dr. Rath and our staff strive to provide you with the highest quality of care. Adequate time is reserved for your cleaning and treatment appointments to meet your dental needs.

When a patient does not show up for their appointment or cancels within 24 hours of their scheduled appointment, we are unable to fill this appointment time with another patient who may desperately need dental care. This policy is an attempt to ensure that both you and our other patients receive the dental care needed, in a timely manner.

### **Rescheduling Appointments:**

We understand that you may need to reschedule your appointments and we ask that you call or text our office as soon as you know that you will not be able to keep the appointment. We ask for a 48-hour notice.

### **Cancelled / Failed Appointments:**

If you cancel an appointment within 24 hours of your appointment, a "cancelled appointment" will be recorded in your dental records.

If you are more than 10 minutes late for an appointment, we may not have enough time for your appointment; we may need to reschedule and this would also result in a "cancelled appointment".

If you miss an appointment, a "failed appointment" will be recorded in your dental records.

If a patient has two "cancelled appointments" or "failed appointments" within a 6 month period, we will not reschedule them another appointment. However, these patients are still welcome to receive their dental care from us. Patients with two cancelled or failed appointments can call us in the morning for a "same day appointment" and if it is available, we will see them that day for treatment.

**I understand the Dental Appointment Agreement and agree to follow the terms of the policy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date