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
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) _____	☐	☐

	YES	NO
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 _____

ASA _____ **(1-6)** 

RADIANCE
FAMILY & COSMETIC DENTISTRY

DENTAL HISTORY
UP TO AGE 14

Patient Name: _____ Nickname: _____ Birthdate: _____

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 are you on a scale of 1 (least) to 10 (most)? _____	☐	☐
2. Have you had an unfavorable dental experience? (Explain) _____	☐	☐
3. Have you ever had complications from past dental treatment? (Explain) _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? (Explain) _____	☐	☐
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 noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐

TOOTH STRUCTURE

	YES	NO
9. Have you had any cavities within the past 3 years? How many? _____	☐	☐

BITE AND JAW JOINT

	YES	NO
10. Do you have any problems with sleep (i.e., restlessness or teeth grinding), waking up with a headache, or having an awareness of your teeth? (Explain) _____	☐	☐
11. Do you wear or have you ever worn a bite appliance? (Provide details) _____	☐	☐

_____ _____
Parent/Guardian Signature Date

_____ _____
Doctor's Signature Date

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RadianceCosmeticDentistry.com

RADIANCE
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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

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RadianceCosmeticDentistry.com

RADIANCE
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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 _____

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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