Bridgman Family Dental Care
Medical History

Legal Name _____ Preferred Name _____

Birthdate _____ Gender: Male _____ Female _____

Have you **ever had** any of the following:

(♦-may need antibiotic premedication)

- ☐ ♦Artificial Joint replacement
  Hip knee other Date of surgery_____
- ☐ ♦Artificial Heart Valve
- ☐ ♦Previous Bacterial Endocarditis
- ☐ Heart Failure
- ☐ Heart Disease or Heart Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Heart Surgery/Stent
- ☐ Heart Pacemaker or Defibulator
- ☐ Congenital Heart Lesions
- ☐ Mitral Valve Prolapse
- ☐ Shortness of breath walking up stairs
- ☐ Swollen ankles during the day
- ☐ Stroke/Family history of stroke
- ☐ Leukemia/Anemia/Sickle cell anemia
- ☐ Cancer/Tumor/Chemotherapy Type _____ Year _____
- ☐ Diabetes; HbA1c_____
- ☐ Thyroid condition
- ☐ Currently smoke; how many cigarettes per day _____
- ☐ Currently vape or use an e-cigarette _____
- ☐ Currently use nicotine in any form
- ☐ Currently using marijuana or any form of a controlled substance
- ☐ Sleep apnea/snoring
- ☐ Osteoporosis or osteopenia
- ☐ Taken: Fosamax/Actonel/Boniva/Bisphosphonates
- ☐ Rheumatoid arthritis
- ☐ Systemic Lupus Erythematosis
- ☐ Migraine headaches
- ☐ Restless leg syndrome
- ☐ Stress/anxiety/depression
- ☐ Post-traumatic stress disorder
- ☐ Epilepsy or Seizures
- ☐ Fainting or dizzy spells
- ☐ Hepatitis A, B, or C
- ☐ Liver disease/Yellow jaundice
- ☐ Ever taken Phen Phen
- ☐ Mononucleosis
- ☐ Hemophilia
- ☐ Blood transfusion
- ☐ Bruise easily
- ☐ Asthma
- ☐ Emphysema
- ☐ Persistent cough
- ☐ Wake up short of breath
- ☐ Tuberculosis (TB)
- ☐ Lost/gained more than 10 lbs quickly
- ☐ Special diet
- ☐ Kidney trouble
- ☐ Ulcers
- ☐ Frequent headaches
- ☐ Prolonged unexplained fever
- ☐ Prolonged infection that was long in clearing up
- ☐ Prolonged unexplained sore throat
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ GERD
- ☐ Auto immune conditions
- ☐ Allergic reaction/hives
- ☐ Arthritis
- ☐ Cortisone medicine
- ☐ Glaucoma
- ☐ AIDS/HIV
- ☐ Physically/mentally handicapped
- ☐ Substance abuse (drug, alcohol)
- ☐ Sexually transmitted disease
- ☐ Nervousness
- ☐ Psychiatric treatment
- ☐ Hearing impaired
- ☐ Alzheimer's or dementia
- ☐ Requires a caregiver
- ☐ Other: _____

Physician's Name _____ Date of last physical _____

City _____ Phone number _____

Have you been admitted to the hospital during the past two years? ☐Yes ☐ No

Have you been told by a doctor to take antibiotics prior to dental appointments? ☐Yes ☐ No

Women – Are you pregnant? ☐Yes ☐ No If yes, what month _____

Do you use birth control medication of any kind ☐Yes ☐ No

Please list all medications you are currently taking (include over-the-counter medications and herbal supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

CONTINUED ON THE OTHER SIDE

Have you ever been allergic to any of the following:

- ☐ Latex/metals/plastics
- ☐ Chlorhexidine
- ☐ Novocaine or Xylocaine
- ☐ Aspirin
- ☐ Demerol
- ☐ Codeine
- ☐ Percodan
- ☐ Valium
- ☐ Nembutal/Seconal (sleeping pills)
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Penicillin/Ampicillin/Amoxicillin
- ☐ Ceclor

Are you aware of being **allergic** to **ANY OTHER** medication or substances?

If yes, please list: _____

Dental History

- ☐ Gums bleed when brushing or flossing
- ☐ Sensitive gums
- ☐ Bad breath/bad taste in mouth
- ☐ Dry mouth
- ☐ Sensitive teeth
- ☐ Food traps between teeth
- ☐ Loose teeth
- ☐ Difficult to open mouth wide
- ☐ Pain around ears
- ☐ Difficulty chewing
- ☐ Clenching/grinding teeth
- ☐ Piercing (face, lip, tongue)
- ☐ Dental implant
- ☐ Gag easily
- ☐ Cold sores/fever blisters
- ☐ Fluoride in drinking water
- ☐ Jaw clicks when chewing

Daily dental health routine: brush ___ x day floss ___ x day other products used _____

Do you have concerns about having dental treatment?	☐ Yes	☐ No
Have you ever had a bad experience in a dental office?	☐ Yes	☐ No
Are you dissatisfied with the appearance of your teeth?	☐ Yes	☐ No
Would you like your teeth to be straighter or whiter?	☐ Yes	☐ No
Have you noticed your teeth shifting or crowding over time?	☐ Yes	☐ No

TO THE BEST OF MY KNOWLEDGE, all the preceding answers are true and correct. I understand that this information will be held in the strictest confidence and be used only to improve communication between Doctor and myself. If I have any change, I will inform the dentist at the next appointment without fail. I hereby authorize Doctor to take any diagnostic records deemed necessary to make a thorough diagnosis of dental needs and to perform any and all forms of treatment and therapy agreed upon by me. I authorize my dental care providers and my medical care providers to communicate with information regarding my dental health status.

✖ _____ _____

Patient Signature Date

OR

✖ _____ _____ _____

Signature of Parent or Responsible Party Relationship to Patient (Parent, Guardian etc.) Dr.

MEDICAL CHANGES/ UPDATES:

DATE	PATIENT'S SIGNATURE	CHANGES	REVIEWED BY	BP
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		

Account Information

Today's Date _____ ☐ SGL ☐ M ☐ SEP ☐ DIV ☐ WID

Responsible Person's Name _____ Preferred Name _____
Last First Middle

Address _____ Home Phone (___)_____
Street City State Zip

Mailing Address (if different from above) _____
Street City State Zip

How long at this address _____ Social Security # _____ Birthdate ____/_____/_____

E mail Address _____ Cell Phone (____) _____

What is the best way to confirm your appointment? ____Home Phone ____Cell phone call _____Text _____Email

Employer _____ Occupation _____ Years Employed _____ Work Phone (___)_____

Spouse's Name _____ Social Security # _____ Birthdate ____/_____/_____
Last First Middle

E mail Address _____ Cell Phone (____) _____

Employer _____ Occupation _____ Years Employed _____ Work Phone (___)_____

How did you learn about our office? ☐ Friend ☐ Relative ☐ Website ☐ Yellow Pages ☐ Other_____

If you were referred to our office, whom may we thank for referring you? _____

Dental Insurance Information

Primary Insurance

Subscriber Name_____

Subscriber SS # or ID #_____

Date of Birth_____

Relationship to Subscriber self/spouse/child/other

Employer Name_____

Insurance Company_____

Insurance Group # _____

Insurance phone #_____

Secondary Insurance

Subscriber Name_____

Subscriber SS # or ID #_____

Date of Birth_____

Relationship to Subscriber self/spouse/child/other

Employer Name_____

Insurance Company_____

Insurance Group # _____

Insurance phone #_____

Emergency Information

Name of nearest relative not living with you_____ Phone (____) _____

I understand, if applicable, I am responsible for all charges including 7% interest fee and/or collection fee of 35-50% that may transpire.

_____ _____
Signature of Patient or Parent/Guardian if Minor Date

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND 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.

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** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Date: _____

Your comments regarding Acknowledgement or Consents: _____

_____

Please list any other parties who can have access to your health information: (This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to **confirm my appointments, treatment, billing information & new health information** via: Check all that apply.

☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐ Other _____

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because the individual refused to sign. Initialed Here: _____

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.