

Health History

Name _____ Date _____

Please answer completely and honestly. If there is any question you do not understand, ask us when this form is reviewed with you. Please use the space available for any details or additional information. Thank you.

- | Yes | No | Do you now or have you ever had ... | |
|-----|--------------------------|-------------------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Bleeding |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or Drug Abuse |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Allergies: <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> Erythromycin <input type="checkbox"/> Jewelry <input type="checkbox"/> Latex <input type="checkbox"/> Metals <input type="checkbox"/> Penicillin
<input type="checkbox"/> Tetracycline <input type="checkbox"/> Other-Please List _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion/Bleeding Disorder |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Therapy |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Surgery |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Do you need to take medication before dental treatment |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | <i>Do you smoke</i> |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Following Tooth Extraction |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Head/Neck/Backaches |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Hives or Rash |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Heart Conditions <input type="checkbox"/> Angina <input type="checkbox"/> Attack <input type="checkbox"/> Murmur <input type="checkbox"/> Surgery |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B, C or Yellow Jaundice |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> | High/Low Blood Pressure |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic Implants: <input type="checkbox"/> Artificial Heart <input type="checkbox"/> Joints <input type="checkbox"/> Heart Valve <input type="checkbox"/> Pacemaker <input type="checkbox"/> Other-Please List _____ |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant: _____ weeks _____ due date <input type="checkbox"/> Birth Control Pills |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| 36. | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| 37. | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| 38. | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| 39. | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| 40. | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| 41. | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers: <input type="checkbox"/> Mouth <input type="checkbox"/> Stomach <input type="checkbox"/> Other-Please List: _____ |

Please list all medications and vitamins you are currently taking.

Who is your primary physician name _____ phone _____
address _____

Signature _____ Reviewed by _____

Dental History

	yes	no	Adult		yes	no	Child
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been satisfied with your prior dental treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is this the child's first dental visit. If not, how long since the last visit _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with your smile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the child eat sweets everyday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you chew your food adequately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the child brush teeth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pleased with how your teeth look, their shape and color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> morning
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush or eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> bedtime
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> after meals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to temperature extremes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the child take fluoride tablets
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you conscious of a bad taste or odor at times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the child received fluoride treatments at school or by a dentist
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any gum (periodontal) treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the child had an unfavorable dental experience
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does food get stuck between your teeth when you eat				

Have you noticed a recent change in:

- color of your teeth
- wrinkles on your face or chin
- shortening of the distance between your nose and chin
- position or spacing of teeth

Do you routinely use:

- toothbrush (___ hard ___ medium ___ soft ___ electric)
- dental floss water pik
- rubber tip other _____
- proxybrush _____
- stimudent _____

Which best describes the way you feel about dental visits:

- relaxed
- a little uneasy
- moderately nervous
- very nervous
- so nervous I feel physically sick

Which best describes the way you feel about dental health:

- a healthy mouth is very important; I expect to keep my teeth for a lifetime
- a healthy mouth is important as long as I don't have to spend much time in your chair
- fill my cavities, but if it requires more treatment than that, pull it out
- I'm going to lose my teeth anyway so why bother

Authorization for release of medical information

In the event it becomes necessary for our office to consult with your physician(s) regarding your medications, treatment, or any matter that would relate to your dental treatment, we would like your permission to do so. By signing the following release, you give us that permission.

signed _____

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care, and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. Our entire staff is dedicated to this concept, and with your cooperation, we will do everything we can to help you reach your goals for dental health.

Patient Name _____ Birth Date _____

Address _____
Street City State Zip

Home Phone _____ Bus. Phone _____ Cell Phone _____

E-mail Address _____ SS# _____

Best way to contact you (Choice 1) _____ (Choice 2) _____

Employer _____ Occupation _____

Business Address _____
Street City State Zip

Spouse's Name _____ SS# _____

Employer _____ Occupation _____

Business Address _____
Street City State Zip

Insurance Carrier Name _____ Group # _____

Person responsible for this account _____

Address _____
Street City State Zip

Home Phone _____ Bus. Phone _____ Cell Phone _____ SS# _____

Whom may we thank for this referral? _____

In Case of an emergency, please contact _____ Relationship _____

Home Phone _____ Bus./Cell Phone _____

Financial Responsibility Agreement

I understand that all services are payable as rendered. I also understand that I am liable to pay for these services in full regardless of payments made by my insurance company. In the event my account is referred for collection, I agree to pay the cost of collection, including 33 1/3% attorney's fees. Under this financial responsibility agreement, I agree to be responsible for my own bill and that of:

Signature of responsible Party _____ Date _____

1021 Sunset Drive, Norfolk VA 23503

Cancellation/Broken/Late Appointment Policy

When we make your appointment, we are reserving a room for your particular needs. Your records are prepared and special instruments are readied for your visit. We ask that if you must change your appointment, please give us at least 48 hours' notice. This courtesy makes it possible to give your reserved room to another patient.

There is a \$50 charge for any cancelled/broken appointment if not done within 48 hours from your scheduled appointment. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patients' time is valuable. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy. We do reserve the right to reschedule your appointment if you are more than 15 minutes late.

Thank you for your understanding.

Patient's Name (Printed)

Date

Patient's Name (Signed)

SUNSET FAMILY DENTISTRY

GENERAL & COSMETIC DENTISTRY

Dr. Mellanda Y. Colson-Scott

1021 Sunset Drive

Norfolk, VA 23503

757-587-1485

AUTHORIZATION TO DISCUSS PATIENT MEDICAL/DENTAL INFORMATION

Date: _____

Expires: _____ N/A _____

To Whom It May Concern:

I, _____, give permission for
(Print your name)

Dr. Colson-Scott and her staff to discuss health concerns and or treatment:

with _____
(Name of person) (Relation to patient)

with _____
(Name of person) (Relation to patient)

with _____
(Name of person) (Relation to patient)

Signature _____ Date _____

Witness _____ Date _____