Dental and Medical History

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

Reason for visit:                                    \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit:                          \_\_\_\_\_\_        Date of last dental x-ray:                    \_\_\_\_\_\_\_

Do you have a personal physician? Yes No Physician’s Name:                   \_\_\_\_    \_\_        Phone #:       \_         \_\_\_\_\_\_

Are you currently under the care of a physician? Yes No Please explain:          \_\_\_\_\_\_\_\_\_\_\_\_\_

Your current physical health is: Good Fair Poor

Yes No Have you ever taken medication prior to a dental appointment?

Yes No Have you ever taken medication for Osteoporosis?

Yes No Are you pregnant? Week #

Yes No Have you been hospitalized in the past 5 years?

Yes No Are you taking any prescription medications?

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                                                                                                                                                          \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medication or anesthetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following diseases or medical problems?

Yes No Respiratory Disease

Yes No HIV Positive

Yes No Liver Disease

Yes No History of Fainting

Yes No Frequent Headaches

Yes No Rheumatic Fever

Yes No Heart Murmur

Yes No Abnormal Heart Condition

Yes No Abnormal Blood Pressure

Yes No Joint Replacement

 If so, when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Abnormal Bleeding

Yes No Alcohol/ Drug Abuse

Yes No Anemia

Yes No Diabetes

Yes No Epilepsy

Yes No Hepatitis

**Dental History:**

How often do you brush?                \_\_\_\_\_\_\_\_\_\_\_\_\_\_                                           How often do you floss?                        \_\_\_\_\_\_\_\_\_

Yes No Do your gums bleed when brushing/flossing?

Yes No Do you grind or clench your teeth?

Yes No Do you currently wear a nightguard?

Yes No Are you interested in whitening?

Yes No Are you interested in straightening your teeth?

Yes No Are you interested in implants to replace missing teeth?

Is there something about your smile/teeth you would like to improve or change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MEDICAL UPDATES FOR STAFF ONLY MEDICAL UPDATES FOR STAFF ONLY

Date \_\_\_\_\_\_\_\_ Medical Changes: N / Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the medical info with this patient. Initials \_\_\_

Date \_\_\_\_\_\_\_\_ Medical Changes: N / Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the medical info with this patient. Initials \_\_\_

Patient Information Form

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

Address:                                                                                                       City:                                               State:          Zip:

Cell Phone:                                                   Home Phone:                                                        Work Phone:

Sex M/F:                   Marital Status:                             Birthdate:     \_\_\_         E-mail:                           \_\_

SS#:              -             -                Name of Responsible Party:

Billing Address:                                                                                           City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_

Name of Employer:                                                               Phone Number of Employer:                                       \_\_\_\_\_\_\_\_\_

Address:                                        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                    City:     \_\_\_\_                             State:           Zip:

Insurance (Y/N):         Insurance Company Name:                   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                 Phone:       \_\_\_\_\_

Insurance Mailing Address:                             \_\_\_\_\_\_\_\_\_                    City:     \_\_\_\_                             State:           Zip:

Group Number:                 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                Patient ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Who referred you to us?:*

Communication Preference: ***Check all that apply***

Email:          Text:           Phone:           Mail:\_\_\_\_

|  |
| --- |
| IN CASE OF EMERGENCY |

Name of local friend or relative (not living at same address):

Relationship to Patient:                                               Home Phone No.:                                      Work Phone No.:

***The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Gordy Family Dental or insurance company to release any information required to process my claims.***

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Us

Phone: 407-422-1130 Fax: 407-841-5651 E-mail: admin@gordyfamilydental.com

1216 Edgewater Drive Orlando, FL 32804

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 407-422-1130.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Must be 18, if not parent/guardian to sign:

Patient Name (Print):

Patient Signature (Parent/Guardian, if a minor):                                                                                         Date:

|  |
| --- |
| HIPPA Compliance |

**Notice to Our Patients**

***Insurance Policy***

So that you can be clear on how our office handles dental insurance, we wanted to share the following information with you:

Our diagnosis and treatment recommendations for you are based on what is best for your oral health and not based on what your dental insurance plan will cover or will not cover. Here at Gordy Family Dental we have opted out from all insurance plans, but our office will, for your convenience, file with your insurance company as long as you have **out-of-network** benefits. With this being said, the patient is responsible for all fees for all services rendered.

***Cancellation and Broken Appointment Policy***

When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us at 48 BUSINESS HOURS notice. This courtesy makes it possible to give your reserved room to another patient who would like it. A charge of $50 will be charged if you do not show up for your scheduled appointment or for repeated cancellations without 48-hour notice. Repeated cancellations or missed appointments may result in loss of future appointment privileges as well. We feel that our patient’s 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 from you.

Our goal is to deliver exceptional care for you and your family in a timely manner, and we appreciate your cooperation by honoring your scheduled appointment times.

Please sign that you have read and understand the above guidelines.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date