Health History

DOWNTOWN DENTAL
SMILE WITH US BOULDER CITY!

Name _____ Date _____

Do you have or have had any of the following? (circle all that apply)

Heart Attack when _____

Stroke when _____

Artificial Valve/valve repair when _____

Artificial Joints where _____ when _____

Infective Endo Carditis when _____

Mitral Valve Prolapse (with or without regurgitation)

Osteoporosis - are you taking bisphosphonates? _____

Cancer/Tumors where _____ when _____

Asthma Do you use an inhaler? _____ how often _____

Epilepsy, Fainting spells, Seizures last episode _____ how often _____

Abnormal Bleeding

High Cholesterol

Liver/Kidney Problems

Diabetes

Hepatitis

Pacemaker

Diagnosed with a sleep disorder

Cough/Swollen Gland

HIV/AIDS

Lung/COPD

Headaches (frequent or severe)

High/Low Blood Pressure

Sinus problems

Thyroid problems

Are you currently taking or have taken any of the following? (circle all that apply)

Corticosteroids

Allergy medications

Blood Thinners

Warfarin (Coumadin)

Apixaban (Eliquis)

Rivaroxaban (Xarelto)

Dabigatran (Pradaxa)

Osteoporosis medications

Bisphosphonates (end in -nate)

end in -umab

* If you experience any acute episode or flare-up, requiring medical attention, you will be referred to **Boulder City Hospital** *or* your preferred care of coordination. In the event of an acute exacerbation where symptoms of the chronic disease worsens rapidly, potentially requiring emergency care or increased medication dosage, we will call EMS: 911.

Please list all current medications including dosage & reason for taking List any additional on back

_____

_____

_____

_____

Are you allergic or have you reacted adversely to any of the following? (circle all that apply)

Antibiotics (please specify) _____

Local Anesthetics (please specify) _____

Acetaminophen or ibuprofen

Aspirin

Latex

Reaction to metals

Codeine

Sulfa Drugs

List all allergies _____

Do you drink alcohol? Current Past How much per day? _____

Do you smoke or use tobacco? Current Past How long? _____

Do you use Marijuana? Current Past How long? _____

Do you now or have you used recreational drugs? None Current Past

If so, what have you used? _____

WOMEN ONLY

Are you pregnant? Y / N If yes, expected due date _____

Are you on birth control? Y / N Are you nursing? Y / N

DOWNTOWN DENTAL

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Dental Health History

Name _____ Date _____

What is the reason for your visit today? _____

Do you have difficulty chewing food?	Yes	No	
Do you have dry mouth?	Yes	No	
Do you avoid brushing any part of your mouth?	Yes	No	Which part?_____
Do you wear dentures/partials?	Yes	No	
Do your gums bleed easily?	Yes	No	
Are your teeth sensitive?	Yes	No	
How often do you floss?	Daily	Weekly	Occasionally
How often do you brush?	Once daily	Twice daily	

Do you feel pain with any of the following?

Hot or cold foods or liquids	Hot	Cold	None
Sweet or sour	Sweet	Sour	None
Pressure	Yes	No	

What cosmetic dental work are you interested in? (circle all that apply)

Invisalign Clear Aligners Implants Bleaching

Are you in need of a bite guard for night, day or sports? Yes No

What describes your past dental problems and care? (circle all that apply)

Regular dental care Occasional dental care

Gum disease (gingivitis or periodontal disease) Yes No

Have you had any adverse reactions to dental treatment? Please describe

_____

_____

Patient/Guardian Signature _____

Dentist Signature _____ Date _____

Insurance Form

DOWNTOWN DENTAL
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Name First _____ Initial _____ Last _____

Social Security Number _____ Birth Date _____

Phone # cell _____ Home _____

Email _____

Preferred method of contact Email Text Phone Postcard

Street Address _____ City _____ State _____ Zip _____

Responsible Party _____ Relationship _____

Social Security Number _____ Birth Date _____

Phone # cell _____ Home _____

Employer Name & Address _____

Primary Insurance Name _____ Phone # _____

Subscriber ID # _____ Group # _____

Secondary Insurance Name _____ Phone # _____

Subscriber ID # _____ Group # _____

Emergency Contact Name _____ Phone # _____

How did you hear about Downtown Dental _____

I certify that I, and/or my dependent(s), have insurance coverage with the above-mentioned insurance company and assign directly to Downtown Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment is due at the time of treatment. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I authorize the use of my signature on all insurance submissions. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

HIPAA

The above named dentist may use my health care information or minor/child's information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have been given the "notice of privacy practices" brochure, read and understand that it covers federal law pertaining to privacy practices. This consent will remain in effect for the duration of the patient/doctor relationship.
Signature for Assignment and Release and HIPAA _____ Date _____

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, administration of anesthetics and dental treatments which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.
Signature for minor/child consent _____ Date _____