NEVADA CITY
SMILES
FAMILY DENTISTRY

MEDICAL HISTORY

- Name: _____ DOB: _____ Phone: _____
- Address: _____ Zip Code: _____
- Email Address: _____ Cell: _____
- Emergency Contact: _____ Relationship to patient: _____ Phone: _____
- Who referred you to our office? _____
- Please list any drugs, medications, supplements, or home remedies you are currently taking or provide a list:

	Medication	**Dose / Frequency**	**Reason for medication**
1.			
2.			
3.			
4.			

5. **SEE ATTACHED LIST** ____

- Are you **allergic** to or have you had a bad or **unusual reaction** to any of the following? (Please circle)

*Penicillin *Sulfa * Motrin *Aspirin *Other _____

*Tylenol * Nitrous Oxide * Codeine *Vicodin * Dental anesthetics * Latex

- **Please list any any other drugs/ materials that you are allergic to:** _____

- Do you have difficulty lying flat in the dental chair? Yes___ No___
- Do you have a difficult time getting numb at the dentists? Yes___ No___
- Do you have difficulty holding open for a 30-40 minute procedure? Yes___ No___
- Do you have anxiety about having dental work? Yes___ No___
- Please **check yes or no** for each of the following medical conditions:

Asthma	Yes___ No___	High Blood Pressure	Yes___ No___	Sinusitis	Yes___ No___
Diabetes	Yes___ No___	Drug Dependency	Yes___ No___	Epilepsy	Yes___ No___
Heart Disease	Yes___ No___	Immunodeficiency	Yes___ No___	Smoking	Yes___ No___
Migraines	Yes___ No___	Psychological	Yes___ No___	Infectious Dz.	Yes___ No___
Resp. Disease	Yes___ No___	Radiation Therapy	Yes___ No___	Cancer	Yes___ No___

- Are you required by your physician to premedicate with antibiotics prior to dental visits for artificial joints or heart valve replacement? **Yes___ No___**
- Have you ever taken bisphosphonate drugs, including Fosamax, Boniva, Aredia, or Zometa? Yes___ No___
- If female, are you pregnant? Which month? _____ Are you nursing? Yes___ No___
- Do you snore? Yes___ No___
- Are you happy with your smile? _____

Is there any other information about your health we should know before we treat you? _____

Patient (or Guardian) signature: _____ **Date:** _____

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INSURANCE:

Insurance Company:_____ **Phone:**_____ **Group#:**_____

Primary Name:_____ **DOB:**_____ **ID/SS#**_____

Employer Name:_____ **Claims Address:**_____

Secondary Insurance:_____ **Phone:**_____ **Group#**_____

Subscriber Name:_____ **DOB:**_____ **ID/SS:**_____

Employer Name:_____ **Claims Address:**_____

Financial Agreement:

Payment for services are due at time of treatment unless prior arrangements have been approved. Our office accepts cash, checks, most credit cards and Care Credit payments. Insurance claims will be submitted for reimbursement for our patients. Most insurance companies pay our office directly with the exception of Delta and some Blue Cross/Blue Shield plans. While we strive to estimate a patient's out of pocket expense, any charges accrued are ultimately the patient's responsibility. ***This office is not a contracted provider with any insurance company.***

I have read and understand my financial responsibility:_____ **Date:**_____

Consent for Dental Treatment:

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

I have read, understood and agree to dental treatment:_____ **Date:**_____

HIPAA Consent:

I acknowledge that I have been given the opportunity to read about my privacy rights as mandated under the HIPAA guidelines. I acknowledge that I was given the opportunity to receive a printed copy of my HIPAA/Privacy rights. Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature of Patient (or Guardian)_____ **Date:**_____