# Highland Colony Dental- Donald K. Givan, DMD

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRAcTICES

*You May Refuse to Sign This Acknowledgement*

I, _____have received a copy of this office's Notice of Privacy Practices.
Print name

_____
Signature Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign ( ) Communication barriers prohibited signing
( ) An emergency prevented us from obtaining acknowledgement ( ) Other (Specify)

**Demographic/ Personal**

Name_____ Date _____

Date of Birth ____/____/____ Social Security # _____

Home Address _____

City_____State_____Zip _____

Home Phone_____ __ Cell Phone_____

Business Name or Student _____

Business Address or School Name _____

Work Number_____ Best Daytime Contact _____

Email address:_____

Whom may we thank for referring you?_____

**Personal:** (office use only)

# Medical History: Prescription and Non- Prescription Medications

Please list all prescription medicines you are taking and reason for taking medication
Continue by listing all non-prescription medicines, herbal or nutritional supplements.

| Prescription medicine name | Reason for medication |
| --- | --- |
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Please list all allergic reactions and adverse reactions to prescription and non-prescription medication. For each medicine, please list type of reaction. ( ie:rash, nausea)

| Medicine/ drug | Type of reaction |
| --- | --- |
| | |
| | |
| | |

I certify to the best of my knowledge that the above is accurate, and that I will inform Dr. Givan or staff of any changes.

Signature_____Date_____

# Dental History

Date of History. _____. Date of last dental/dental hygiene visit _____.

Chief dental concern_____.

Frequency of dental care_____. Hx of speciality care _____.

Any recent radiographs_____. Type(s)_____Location_____.

Any emergency care in past 2 years_____.

History of head and neck radiation_____.

Any unusual reaction to dental anesthetics_____.

History of N2O(Laughing Gas)_____ unusual reaction_____.

History of TM joint problems_____Treatment_____.

History of bruxism_____Appliance_____.

History of facial or jaw injuries_____.

History of jaw surgery_____Orthodontics_____.

History of prolonged bleeding after dental surgery_____.

Mouth breather _____ Snoring_____Sleep apnea_____.

Chew on one side_____ Reason_____.

Chief reason for visit today_____.

Cosmetic concerns:

What would you change about your teeth or smile_____

_____Bleaching_____.

# MEDICAL/ DENTAL HISTORY

Name_____Birth Date_____

Name of Physcian(Medical Doctor)_____date of last visit_____

Physcian's address_____

**WELCOME!** We are pleased to welcome you to our practice .The following information is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate in formation is necessary to safely and efficiently protect your health. Incorrect informaiton can be dangerous to you and compromise our ability to provide appropriate and healthful dental care. if you have any questions, we will be happy to help!

## General

- Are you in good general health? _____

- Any change in your health in the past year? yes, no / reason_____

- Are you under the care of a physician? yes, no / reason_____

- Date of last physical?_____

- Have you been hospitalized or had a serious illness or major operation?_____

_____

## Systems Review

**Please Circle conditions you have had in the past or currently have.**

**Cardiovascular System**

Mitral valve prolapse, heart murmur, valve dysfunction, rheumatic fever, rheumatic heart disease

Previous bacterial endocarditis, artificial heart valve, systemic pulmonary shunt, cogential heart defect

Heart disease, heart failure, chest pain, heart attack, date_____, heart surgery, date_____

Pacemaker, replaced artery, date_____, High blood pressure, low blood pressure, arrhythmia

Circulatory problems in the body, circulatory problems in the head or neck, bypass surgery in the body

Cerebrovascular accident (stroke), fainting spells, other_____

**Hematopoietic** (blood coagulation disorders)

Excessive bleeding, hemophillia, clotting problems_____

**Respiratory System**

Lung disease, persistant cough or cold, bronchitis, tuberculosis, emphysema, pneumonia,

Shortness of breath, asthma, chronic sinus problems, seasonal allergies ( hay fever )

**Digestive System**

Stomach ulcers / acid reflux, chronic indigestion, diarrhea, jaundice, liver disease, hepatitis A, B, or C

**Genitourinary System**

Kidney disease / failure, renal dialysis, kidney transplant

Sexually transmitted diseases, AIDS, ARC, HIV, herpes virus

**Skeletal System** (bones / joints)

Arthritis, swollen joints, inflammatory rheumatism, osteoporosis

Artificial joint(s): hip, knee or other joint, date placed _____

**Neuro/ physchological conditions**

Fainting spells, seizures, frequent headaches, epilepsy, paralysis, Alzheimers disease

Multiple Sclerosis, Parkinsons, clinical depression or anxiety, psychiatric treatment

Drug dependence, substance abuse, alcohol, tobacco use, other_____

**Endocrine System**

Frequent thrist, frequent urination, thyroid disease: hypoththyroidism, hyperthyroidism

Diabetes controlled/ uncontrolled, if yes: **Type I,** insulin dependent or **Type II**, adult onset

**Multiple System**

Cancer, cancer treatment, treatment for tumor or growths, radiation, chemotherapy

Organ transplant, immunosuppressant therapy, cortisone treatment

Have you had any other condition or disease not previously mentioned?_____

**Women-Pregnancy/ Menopause**

Are you pregnant?_____, How many months?_____, Nursing?_____

Are you taking birth control medication(s)?_____

Are you taking hormone replacement?_____

I have reviewed the information on this questionare and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Givan and his staff to help determine appropiate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Givan.
I authorize my insurance company to pay Dr. Givan all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I aurthorize Dr Givan to release all information necessary to secure the payment of benefits.I also understand that I am fully financially responsible for all charges whether covered, not covered or declined by my insurance company, I understand that proper dental decisions are made between the patient and the Dentist, and not the insurance company. I understand that since treatment plans are explained and decisions are made mutually before treatment is begun, I give my consent to perform any needed dental treatment, including the use of local anesthetics as needed. ( I also give consent for the use of photographs for patient education purposes: agree / disagree)

**Signature of patient,**
**parent or legal guardian** _____**date**_____