## New Patient Form - Medical, Rx, Dental Date:_____

**Patient Name:**_____

**Gender:**_____**Date of Birth:**_____ **Age:**_____

**SSN:**_____-_____-_____

**Address:**_____

**City, State Zip:**_____

**Home Phone:**_____

**Work Phone:**_____

**Cell Phone:**_____

**Email Address:**_____

## Additional Demographics

**Employer Name Or Student:**_____

**Employer Address or School:**_____

**Whom may we thank for referring you and relationship to you:**_____

**Do we have permission to send them a thank you note:**_____

**Additional Comments:**_____

_____

_____

## Medical History: Drugs and Allergies

**Rx Meds:**_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Med Allergies:**_____

**Preferred Pharmacy and Location**:_____

## Medical History: General

**Are You In Good Health:** YES/NO

**Any Recent Change In Your Health:** YES/NO

**Reason:**_____

**Under A Physician's Care:** YES/NO

**Reason:**_____

**Date of Last Physical:**

**Hospitalizations, Serious Illness, Major Surgeries:**

## Medical History: Systems Review Copy

### Cardiovascular System

**Mitral Valve Prolapse:** YES/NO

**Heart Murmur:** YES/NO

**Valve Dysfunction**: YES/NO

**Rheumatic Fever**: YES/NO

**Rheumatic Heart Disease:** YES/NO

**Past Infective Endocarditis (IE):** YES/NO

**Date:**_____

**Heart Valve Replacement:** YES/NO

**Date:**_____

**Type:**_____

**Heart Transplant:** YES/NO

**Date:**_____

**Damaged Valves In Transplanted Heart:** YES/NO

**Systemic Pulmonary Shunt:** YES/NO

**Congenital Heart Disease (CHD):** YES/NO

**Unrepaired, Cyanotic CHD:** YES/NO

**Repaired CHD W/Residual Defects:** YES/NO

**Completely Repaired CHD In Last 6 Mos**: YES/NO

**Heart Disease:** YES/NO

**Heart Failure:** YES/NO

**Chest Pain:** YES/NO

**Heart Attack:** YES/NO

**Date:**_____

**Pacemaker:** YES/NO

**Bypass Surgery (Heart):** YES/NO

**Date:**_____

**Bypass Surgery (Body: Head/Neck/Abdomen/Arm/Leg):** YES/NO

**Site(s), Date(s):**_____

**High Blood Pressure:** YES/NO

**Low Blood Pressure:** YES/NO

**Arrhythmia:** YES/NO

**Circulatory Problems (Body):** YES/NO

**Circulatory Problems (Head/Neck):** YES/NO

**Bypass Surgery (Body):** YES/NO

**Cerebrovascular Accident (Stroke):** YES/NO

**Fainting Spells:** YES/NO

**Others:**_____

## Hematopoietic

**Excessive Bleeding:** YES/NO

**Hemophilia:** YES/NO

**Clotting Problems:** YES/NO

**Details:** _____

## Respiratory System

**Lung Disease:** YES/NO

**Persistent Cough/Cold:** YES/NO

**Bronchitis:** YES/NO

**Tuberculosis:** YES/NO

**Emphysema:** YES/NO

**Pneumonia:** YES/NO

**Shortness Of Breath:** YES/NO

**Asthma:** YES/NO

**Chronic Sinus Problems:** YES/NO

**Seasonal Allergies (Hay Fever):** YES/NO

## Digestive System

**Stomach Ulcers/Acid Reflux:** YES/NO

**Chronic Indigestion:** YES/NO

**Diarrhea:** YES/NO

**Jaundice:** YES/NO

**Liver Disease:** YES/NO

**Hepatitis:** YES/NO

**Specify:** _____

_____

## Genitourinary System

**Kidney Disease/Failure:** YES/NO

**Renal Dialysis:** YES/NO

**Kidney Transplant:** YES/NO

**Sexually Transmitted Diseases:** YES/NO

**AIDS:** YES/NO

**ARC:** YES/NO

**HIV:** YES/NO

**Herpes Virus:** YES/NO

## Skeletal System

**Arthritis:** YES/NO

**Swollen Joints:** YES/NO

**Inflammatory Rheumatism:** YES/NO

**Osteoporosis:** YES/NO

**Artificial Joint(s):** YES/NO

**Joint(s) And Date Placed:**_____

**Artificial Joint(s) with any one of the following conditions: type 1 diabetes (IDDM), immunosuppression, rheumatoid arthritis, lupus, HIV, hemophilia, previous prosthetic infection, obesity, smoking:** YES/NO

**Details:**_____

_____

## Neuro/Psychological Conditions

**Fainting Spells:** YES/NO

**Seizures:** YES/NO

**Frequent Headaches:** YES/NO

**Epilepsy:** YES/NO

**Paralysis:** YES/NO

**Alzheimer's Disease:** YES/NO

**Dementia:** YES/NO

**Multiple Sclerosis:** YES/NO

**Parkinson's Disease:** YES/NO

**Clinical Depression/Anxiety:** YES/NO

**Psychiatric Treatment:** YES/NO

**Drug Dependence:** YES/NO

**Substance Abuse:** YES/NO

**Alcohol Abuse:** YES/NO

**Tobacco Use:** YES/NO

**Other:**_____

## Endocrine System

**Frequent Thirst:** YES/NO

**Frequent Urination:** YES/NO

**Thyroid Disease:** YES/NO

**Specify:** _____

**Diabetes Controlled, Type 1 (IDDM):** YES/NO

**Diabetes Controlled, Type 2 (non-insulin dependent):** YES/NO

**Diabetes Uncontrolled:** YES/NO

## Multiple System

**Cancer:** YES/NO

**Cancer Treatment:** YES/NO

**Type/Date:** _____

**Treatment for Tumor/Growths:** YES/NO

**Radiation:** YES/NO

**Chemotherapy:** YES/NO

**Organ Transplant:** YES/NO

**Immunosuppressant Therapy:** YES/NO

**Cortisone Treatment:** YES/NO

## Other Conditions/Disease Not Listed Above

# Medical History: Women

**Are You Pregnant:** YES/NO

**How Many Weeks:** _____

**Nursing:** YES/NO

**Taking Birth Control Meds:** YES/NO

**Taking Hormone Replacement:** YES/NO

## Dental History

**Today's Date:**_____

**Date of Last Dental/Hygiene Visit:**_____

**Chief Dental Concern:**_____

**Frequency of Care:**_____

**History of Specialty Care:**_____

**Any Recent Radiographs:**_____

**Types:**_____

**Locations:**_____

**Emergency Care in Last 2 Years:** YES/NO

**History Of Head/Neck Radiations:** YES/NO

**Unusual Reaction to Anesthetics:** YES/NO

### History

**History of N2O (Laughing Gas):** YES/NO

**Reaction:**_____

**History of Jaw Joint (TMJ or TMD) Problems:** YES/NO

**Treatment:**_____

**History of Bruxism (Grinding/Clenching):** YES/NO

**Appliance:**_____

**History of Facial/Jaw Injuries:** YES/NO

**History of Jaw Surgery:** YES/NO

**Explain:**_____

**Prolonged Bleeding After Surgery:** YES/NO

**History of Orthodontics (Braces):** YES/NO

**Mouth Breather:** YES/NO

**Snoring:** YES/NO

**Sleep Apnea:** YES/NO

**Chew On One Side:** YES/NO

**Reason:**_____

**Chief Reason For Visit Today:**_____

**What would you change about your teeth or smile:**_____

**Bleaching:**_____

## Acknowledgement

I have reviewed the information of this questionnaire 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 appropriate 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 the signature on all insurance submissions. I authorize 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 have read and understand the above information.**

**Signature:**_____ Date:_____

# HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy

A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

- Protect health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of a breach of your Protected Health Information under certain circumstances.
- you have the right to be notified of a breach of unsecured Protected Health Information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent,

Signature _____Date:_____