# Armfield Dentistry

*As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.*

Today's Date____________________

Patient's name ______________________________________________ Preferred name ___________________ Birth date____________

If minor, Mothers name _______________________________ Fathers name________________________________

Home phone _________________________ Work phone ____________________________ Cell_________________________

Email___________________________________________________________❑ Male ❑ Female

Mailing address ___________________________________________ City ____________________State ________ Zip ____________

Employer ____________________________________ Occupation _____________________________________________________

Spouse's name _________________________________ Spouse's employer __________________________________ ❑ Unmarried

Spouse phone___________________________ Whom may we thank for referring you to our office? _____________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: ______________________ Dental Insurance Co.__________________ Group number_____________

Covered by spouse's insurance? ❑ yes ❑ no Dental ID#_______________________

Spouse's dental insurance company _______________________ Group number ___________________

Spouse's birthday _______________________ Social Security number ____________________________

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

**(Please check any that apply)**

- ❑ Cancer/Chemotherapy/ or tumor
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial heart valve
- ❑ Sleep Apnea
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis B or C or other liver disease
- ❑ Current or previous substance abuse
- ❑ Blood transfusion If yes, what date:_________________
- ❑ Diabetes type I or II
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition If yes, Describe________________
- ❑ Autism
- ❑ Multiple Sclerosis (MS)
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma or COPD
- ❑ Persistent swollen glands in neck/Thyroid
- ❑ Recurrent infections
- ❑ Eating Disorder

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
  If so, what? ________________________________
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_______________________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Injections for Actonel, Boniva, Fosamax, Zometa, or Aredia
- ❑ Narcotics ( Lortab, Norco, Tramadol, Morphine, etc)
- ❑ Preferred Pharmacy___________________________
- ❑ Please list prescriptions on seperate page provided

Women:

- ❑ May be pregnant
  Expected delivery date: _____________
- ❑ Taking hormones, contraceptives, implant

Name:________________________________ DOB________________________ID#______________

Please list any medications or supplements that you are currently taking on the lines below.

| Medication | Use | Dose | Provider Initials |
|---|---|---|---|
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Name:________________________________ DOB________________________ID#__________________________________

Name of your physician:_______________________________________________________________________________

Do you have any disease, condition, or problem not listed above?_____________________________________________________

________________________________________________________________________________________________________

- ❑ Do your gums bleed when you brush or floss?
- ❑ Sensitivity to cold, hot, sweets or pressure?
- ❑ Food or Floss catch between your teeth?
- ❑ Dry mouth
- ❑ Had periodontal (gum) treatments?
- ❑ Previous orthodontic (braces) treatment?
- ❑ Any problems associated with previous dental treatment?
- ❑ Do you brux or grind your teeth?
- ❑ Do you have sores or ulcers in your mouth?
- ❑ Do you wear partials or dentures?
- ❑ Are you currently experiencing dental pain or discomfort?
- ❑ Do you have earaches or neck pains?
- ❑ Drink carbonated, sports, or energy drinks on regular basis?
- ❑ Have you ever had a serious injury to your head or mouth?
- ❑ Suck finger or thumb?
- ❑ Nail biting?
- ❑ Nursing bottle habits?
- ❑ Date of your last dental exam:______________________
- ❑ What was done at that time? _______________________
- ❑ Date of last dental x-rays: _________________________
- ❑ Where:___________________________________________
- ❑ Other:___________________________________________

Your health and well being is very important to us. We appreciate the confidence and trust that you have placed in us. Please read our policies and feel free to ask any questions.

**Broken/Missed Appointments:** We request at least 48 hours' notice before cancelling or rescheduling an appointment. That way, we have some time to try and care for another patient. We will allow ONE (1) rescheduled appointment per patient. If you do not show or call to reschedule an appointment, unfortunately we will not be able to reschedule your appointment. It is very important to schedule appointments that will fit into your schedule.

**Confirmation Policy**

If our office is unable to confirm your dental appointment by 24 hours prior verbally or electronically with you, we do reserve the right to cancel your appointment and reappoint to another patient. Please be sure to keep us in mind when you change your phone numbers or E-mail to avoid this situation.

Cell#________________________ Can you receive text messages? **yes** or **no**

Contact info for someone living outside the home: Name____________________________#________________

**Minor/Child Office and Treatment Policy**

In our office, we ask that parent(s) stay in the reception area while we are treating your child. Experience has shown that children do much better with a "one-on-one" setting. We invite you to take a tour of our office if you would like. You will be asked to go back to the treatment area during your child's examinations, or if necessary, during any future visits. Please be assured that we will do everything possible to make your child's visits comfortable and enjoyable.

*By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).*

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You may Refuse to Sign This Acknowledgement

I have received a copy (or been offered a copy) of this office's Notice of Privacy Practices.

Please Print Name:_____________________________ Signature: ____________________________

Date: _______/_______/_______

Other family members: ____________________________________________________________________

Name:______________________________DOB________________________ID#______________

Please list any surgeries or medical procedures that you have had.

| Date: | Surgery | Surgeon | When | Provider Initials |
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