Heath Springs Dental Associates P.A.

Medical History

Patient Name: ______________________________

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to complete the following information.

How did you hear about us? ______________________

Your main reason for your appointment today: _________________________________

Your Primary Area of Concern? (please circle)
Location:
- Upper Left
- Upper Right
- Lower Right
- Lower Left

Duration:
- Very Short
- 1 to 5 min
- 5 min to an hour
- More than an hour

Severity
- Mild
- Moderate
- Severe

Your Medical History

Patients Height: _____________

Patients Weight: _____________

Physicians Name: ____________________________

Physicians Address and Telephone # ___________________________________

____

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Are you currently seeing physician for anything other than just regular check ups?

- Yes
- No

Previous Conditions (please circle)

- None
- Alcohol addiction
- Anemia
- Anorexia
- Arthritis / Rheumatism
- Artificial (prosthetic) heart valve
- Artificial joint / Prosthesis
- Autoimmune disease
- Blood Disorder
- Bulimia
- Cancer
- Chemical Dependency
- Chemotherapy
- Cortisone medication
- Damaged valves in transplanted hear
- Diabetes Type I
- Diabetes Type II
- Drug dependency
- Emphysema
- Epilepsy
- Fainting spells
- Gastrointestinal disease
- GERD (gastric reflux)
- Glaucoma
- Hearing impairment
- Heart disease / surgery
- Heart Murmur
- Heart Pacemaker
- Hemophilia
- Hepatitis other
- Hepatitis A
- Hepatitis B
- Hepatits C
- High / Low Blood Pressure
- HIV positive / AIDS / ARC
- Kidney problems
- Learning Disability
- Leukemia
- Liver disease
- Lung Disease / COPD
- Mental Health Disorder
- Mitral Valve Prolapse

- Neurological disorder
- Organ transplant
- Osteoporosis
- Persistent swollen glands
- Previous Infective endocarditis
- Prolonged Bleeding
- Radiation Therapy
- Removal of spleen
- Repaired CHD in last 6 months
- Repaired CHD with residual defects
- Respiratory ailments
- Rheumatic Fever / Heart Disease
- Shortness of breath
- Sickle Cell Disease
- Sinus trouble
- Stroke
- Thyroid Problems
- Tuberculosis
- Tumors
- Ulcers
- Un-repaired, cyanotic CHD
- Venereal disease

History of other serious illness, hospitalization or accident:
- Yes
- No

Additional Medical Conditions or Concerns:
- Yes
- No

Alcohol Consumption:
- Yes
- No

Recreational Drug Use:
- Yes
- No

Would you consider yourself to be in fairly good health:
- Yes
- No

Has there been any changes in your general health lately:
- Yes
- No

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Women: Are you pregnant?:
- Yes
- No
- Possibly

Allergies: ____

Medications (please list):

____

____

____

Smoking Status

- Never Smoker
- Current every day smoker
- Light smoker
- Heavy smoker
- Quit Smoking how long: _________

Your Dental History

Previous Dentist: ______________________________

Location of previous dentist: ______________________________

Teeth Sensitive to the following:
- Hot
- Cold
- Sweets
- Pressure

Nervous about dental treatment:
- Yes
- No

Previous Orthodontic Treatment:

- Traditional Braces
- Invisalign or Clear Correct
- Other
- No

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Happy with Smile:
- No
- Yes

Do your gums bleed when you brush or floss:
- No
- Yes

Do you clench or grind:
- No
- Yes

Treatment History of Gum Disease:
- No
- Yes

Are any of your teeth currently causing you pain:
- No
- Yes

Have you ever had any periodontal treatment:
- No
- Yes

Are you concerned with loose teeth or teeth loosening:
- No
- Yes

Do you have any dental implants, dentures, or partials:
- No
- Yes

Do you have any clicking or pain in your jaw:
- No
- Yes

Do you drink Well Water?:
- No
- Yes

Emergency Contacts

Emergency Contact Name: ____

Emergency Contact Phone Number: ________________________________

Emergency Contact Relationship: ___________________________________

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General Consent
I, know that I am in need of emergency or routine dental care requiring diagnostic, dental or surgical treatment do hereby voluntarily consent to such procedures and care: dental, medical, surgical, and/or other services under the general and specific instructions of Dr. David M. DeCillis or Dr. Christopher B. Phillips. I also acknowledge the practice of dentistry is not an exact science and that no guarantees have been made to me as to the results of treatments or examinations by either Doctor. I authorize Heath Springs Dental Associates, P.A. (HSDA) to release my HIPPA information to all my insurance carriers to process claims. I understand that I am responsible for my account including all expenses not paid by insurance. I authorize HSDA to act as my agent to help obtain payment from my insurance and authorize payment directly to the practice. I acknowledge receipt of the financial policies of the office and agree to abide by them.

Do you prefer to see a particular Doctor?:
- Dr. Decillis
- Dr. Phillips
- No Preference

Patient Signature
My signature below indicates my consent to the above procedure(s).

Sign Here: ______________________________________ Date: ________________________