

Please identify any allergic reactions:

- None
- Latex
- Dental anesthetics, like novocaine
- Penicillin
- Pain meds or narcotics
- Cephalixin
- Aspirin
- Sulfa
- Erythromycin
- Other: _____

Have you been hospitalized or needed emergency treatment in the past 2 years? Please explain:

Name of your physician(s):

Do you have any of the following:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement or implant
Type: _____ Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic heart disease or Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart defect or murmur
Explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease, heart attack, chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or defibrillator (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Need for dental "premedication" |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure problems <input type="checkbox"/> High <input type="checkbox"/> Low |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or other blood disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/Clotting disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous disorder |

Please identify any current dental problems:

- Gums bleed with brushing/flossing
- Sensitivity to hot/cold foods
- Pain in any of your teeth
- Sores or lumps in or near your mouth
- Dry mouth

What would you like to change about your teeth or smile? circle: Brightness Tooth color

Crowding Chipped or cracked teeth Missing teeth
Other: _____

List the names of all your current medications:

- None _____
- _____
- _____
- _____
- _____

Do your medications include the following:

- Yes No Blood thinners (including daily aspirin)
- Yes No Bisphosphonates (bone density drugs)

Women only:	Yes	No
Are you pregnant or think you may be?	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis or persistent cough (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing problems or asthma (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease or arthritis (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease or jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (Type/Date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach trouble/ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain, popping or clicking |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke, chew tobacco, vape? (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Patient Name: _____

Signature: _____

Relationship: _____ **Date** _____

Staff signature: _____

Notes: _____

METTMAN DENTAL

HIPAA CONSENT

Please update patient information;

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

ARE WE ALLOWED TO LEAVE A DETAILED TEXT OR EMAIL MESSAGE?

YES

NO

IT IS THE PATIENT'S RESPONSIBILITY TO KEEP PHONE NUMBERS, EMAIL AND ADDRESSES UP TO DATE. WE WILL CONFIRM VIA EMAIL, TEXT, AND PHONE CALLS

WITH WHOM MAY WE SHARE YOUR PROTECTED HEALTH INFORMATION?

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Allergies: _____

NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE PRIVACY POLICY NOTICE (HIPAA) AND OFFICE POLICIES AND PROCEDURES. WE WILL ONLY USE YOUR PROTECTED HEALTH INFORMATION (PHI) FOR THE PURPOSE OF TREATMENTS, PAYMENTS, HEALTHCARE OPERATIONS, AND COORDINATION OF CARE.

I authorize the transfer of radiographs and dental records for the referred treatment if a transfer is made to another general dentist or dental specialist.

Photographs, x-rays, and digital images may be used for diagnosis, documentation, reference, teaching. Please initial the following:

_____ I authorize the use of images and radiographs for the patient listed above

_____ I DO NOT authorize the use of images and radiographs for the patient listed above

INFORMED CONSENT AGREEMENT

I give consent to receive dental treatment deemed necessary by the providers at Mettman Dental. These procedures include, but are not limited to examinations, oral prophylaxes, fluoride treatments, sealants, fillings, crowns, bridges, implants, dentures, periodontal treatment, extractions and the use of local anesthetic and nitrous oxide. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or in rare cases, prolonged or permanent nerve damage. This consent shall be considered in effect until rescinded or revoked in writing.

PATIENT SIGNATURE (PARENT OR GUARDIAN)	DATE

THIS DOCUMENT SHALL EXPIRE ON 12-31-2030