West Union Dental Associates

PATIENT INFO

Patient's Name_____

Date of Birth_____Age_____SSN_____ [ ] minor [ ] single [ ] married [ ] widowed

Name of Spouse (if applicable) _____

Name of Parent (if applicable) _____

Home Address_____

Home Phone (___) _____Cell Phone (___) _____

Email address_____

How would you prefer we contact you to confirm your appointment? [ ]phone call [ ] email [ ] text message

Name of Employer_____Work Phone (___) _____

Whom may we thank for referring you? _____

Are you covered by dental insurance? **Yes** **No**

Estimated copays are due on day of service.

How do you intend to pay for your treatment? **Cash** **Check** **Credit Card** **Care Credit**

We offer 5% discount to those without insurance if balance is paid IN FULL on the DAY OF treatment with CASH or CHECK ONLY!

DENTAL INSURANCE

Primary Dental Insurance

Insured Name_____SS#/ID#_____Date of Birth_____

Insured's Employer_____Insurance Plan Name_____Group #_____

Customer Service Telephone_____Patient's relationship to insured_____

Secondary Dental Insurance

Insured Name_____SS#/ID#_____Date of Birth_____

Insured's Employer_____Insurance Plan Name_____Group #_____

Customer Service Telephone_____Patient's relationship to insured_____

100 East Bradford
West Union, IA 52175
563-422-6292

Time 4:13 PM

West Union Dental Associates

Date 11/2/2016

Updated Medical History II

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you in good health?	◯ Yes ◯ No	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have there been any changes in your general health within the past year?	◯ Yes ◯ No	
Do you have any damaged heart valves or artificial heart valves?	◯ Yes ◯ No	
Have you ever taken Fosamax, Actonel, Zometa or any other medications containing bisphosphonates (oral or	◯ Yes ◯ No	If yes
Have you had any joint replacements (knee, hip, shoulder)? If so, when:	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco? If so, how much:	◯ Yes ◯ No	If yes
Have you currently, or ever been, instructed to take antibiotic pre-medication prior to dental treatment?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant, due_____ ☐ Nursing ☐ Birth control/contraceptives ☐ Hormone therapy

☐ Other_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anasthetics

☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other_____

If any, please explain: Comment

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

Head and Neck

Sinus problems or allergies	◯Yes ◯No	Pain in jaw joint or TMJ	◯Yes ◯No	Hearing impaired	◯Yes ◯No	Headaches	◯Yes ◯No
Fever blisters/canker sores	◯Yes ◯No	Radiation treatments	◯Yes ◯No	Cancer, year_____	◯Yes ◯No	Other_____	◯Yes ◯No

Lungs

Asthma	◯Yes ◯No	Emphysema	◯Yes ◯No	Tuberculosis	◯Yes ◯No	Difficulty breathing	◯Yes ◯No
Respiratory problems	◯Yes ◯No	Other_____	◯Yes ◯No				

Stomach

Acid Reflux/GERD	◯Yes ◯No	Ulcers	◯Yes ◯No	Colitis	◯Yes ◯No	Surgery	◯Yes ◯No
Other_____	◯Yes ◯No						

Liver

Hepatitis A/B/C	◯Yes ◯No	Liver disease/Jaundice	◯Yes ◯No	Other_____	◯Yes ◯No		

Heart

High blood pressure	◯Yes ◯No	Low blood pressure	◯Yes ◯No	Angina/Chest pains	◯Yes ◯No	Heart disease or heart attack	◯Yes ◯No
Congestive heart failure	◯Yes ◯No	Pacemaker, year_____	◯Yes ◯No	Stroke	◯Yes ◯No	Heart surgery, year_____	◯Yes ◯No
Artificial heart valve	◯Yes ◯No	Past infective endocarditis	◯Yes ◯No	Congenital heart condition	◯Yes ◯No	Heart murmer	◯Yes ◯No
Other_____	◯Yes ◯No						

Blood

Abnormal bleeding	◯Yes ◯No	Anemia	◯Yes ◯No	Hemophilia	◯Yes ◯No	Blood clots	◯Yes ◯No
HIV/AIDS	◯Yes ◯No	Other_____	◯Yes ◯No				

Kidney

Dialysis	◯Yes ◯No	Transplant, year_____	◯Yes ◯No	Failure/Disease	◯Yes ◯No	Other_____	◯Yes ◯No

Joints

Artificial hip, year_____	◯Yes ◯No	Artificial knee, year_____	◯Yes ◯No	Arthritis, type_____	◯Yes ◯No	Surgery	◯Yes ◯No
Other_____	◯Yes ◯No						

Systemic Disease

Diabetes	◯Yes ◯No	Cancer, year_____	◯Yes ◯No	Chemotherapy	◯Yes ◯No	Radiation treatment	◯Yes ◯No
Thyroid disease	◯Yes ◯No	Epilepsy or seizures	◯Yes ◯No	Syphilis/Gonorrhea/Herpes	◯Yes ◯No	Drug or alcohol problems	◯Yes ◯No
Surgery_____	◯Yes ◯No	Other_____	◯Yes ◯No				

Have you ever had any serious illness not listed above? ◯Yes ◯No If yes

Medications:

List medications you are currently taking and why (including nonprescription, herbal supplements, or controlled substances). Please print clearly.

Dental History

What is the reason for your visit today? Comment

Have you had any of the following

Periodontal Disease	◯Yes ◯No	Fillings	◯Yes ◯No	Crowns	◯Yes ◯No
Orthodontic work	◯Yes ◯No	Oral surgery	◯Yes ◯No	Implants	◯Yes ◯No
Clenching/Grinding	◯Yes ◯No				

Last dental cleaning Comment

Last dental x-rays Comment

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon me and to employ such assistance as required to provide proper care.

3. I fully agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5 % late charge (18% APR) may be added to my account.

PHOTO RELEASE

I grant permission to West Union Dental Associates to use my intraoral photographs and radiographs for educational purposes. West Union Dental Associates are able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that these photos are only of my teeth and that **my name or my face will not be shown.**

_____
Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the **NOTICE OF PRIVACY PRACTICES** of this office.

_____
Printed Name

_____
Parent/Guardian Printed Name
(If under age of 18)

_____Date_____
Signature

_____Date_____
Parent/Guardian Signature
(If under age of 18)

NOTE: A full copy of our Privacy Practices is available at our reception desk, if you would like a copy to read and keep, please ask.