Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

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. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation:
Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Thomas M. Loe, D. D. S.
10320 Venice Blvd.
Culver City, CA 90232

NOTICE OF PRIVACY PRACTICE: THOMAS M. LOE, D.D.S.

(We have always kept your health information confidential. A new law requires us to provide you with this notice)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU COULD OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your treatment plan and health information will be available in your records to all health professionals.

PAYMENT: Your health information may be used to seek payment from your dental insurance plan, other sources of coverage such as an automobile insurer or from credit card companies. For example, your dental plan may request and receive information on dates of service along with services provided.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day to day activities and management of the office of Thomas M. Loe, D.D.S. For example, information on the services you received may be used to support billing, financial reporting and activities to evaluate and promote quality. Our business associates, such as a billing service, are also required to protect your privacy. We may send you newsletters or other information. We may call and remind you about your appointment but if you are not able to come to the phone, we may leave information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or person responsible for your care.

LAW ENFORCEMENT: Your health information may be disclosed when required by law (without your consent) to facilitate law enforcement investigation and to comply with government mandated reporting and personnel.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

- Except as described above, this practice will not use or disclose your health information without your specific prior written authorization.
- You have the right to request an amendment or change. Your request must be in a written form. However, your decision to revoke the authorization will not affect or undo any use of disclosures that occurred before you notified us of your decision.
- You have the right to receive confidential communications concerning your medical condition and treatment.
- You have the right to see and copy your protected health information, with a few exceptions. Please give our office a written request and reasonable time regarding the information you require. Files will be mailed or faxed to you, if transferred to another practice.
- You have the right to know of any uses or disclosures of your health information beyond regulatory use.
- You have the right to receive a copy of this notice. As permitted by law, we reserve the right to amend or modify our practice privacy. You will be provided with a revised notice on your next office visit.

If you have questions or concerns, please submit a form in writing to the Department of Health and Human Services, 200 Independence Ave SE, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
This notice goes into effect as of April 14, 2003
Acknowledgement: I have received a copy of the Thomas M. Loe, D.D.S. Notice of Privacy Practices.

Date:_____ Signature:_____ Printed Name:_____

If signing as a parent or guardian, please note the name of the patient: _____

Thomas M. Loe, D.D.S.

10320 Venice Blvd.

Culver City CA 90232

FINANCIAL POLICY STATEMENT

Thank you for selecting us to serve your dental needs. Our goal is a successful treatment for your total dental care. Please understand that payment is essential for the efficient functioning of our office, so we may better serve you. We ask that you read the following financial statement and sign prior to your appointment. Please let us know if you have any questions or concerns.

Private Patient: Full payment is expected at the time of service.

Insurance: It is your responsibility to understand the benefits and limitations under your insurance plan and contact the insurance company if you have any questions. Your eligibility status does not confirm payment from your insurance company. With your consent, our office will submit a claim to your dental insurance and send a statement to you after we have received a payment from the insurance company. No patient responsibility is finalized until a claim is submitted and we have received payment from the insurance.

(Insurance) non-covered services: Non-covered services such as bleaching procedures, night guards, certain fillings, etc., will be billed directly to you and must be paid at the time of service.

Missed Appointments: To cancel an appointment, a 24-hour notice is required. If your call is after hours, please leave a voicemail indicating you will not be able to keep your appointment. Arriving late to your scheduled appointment may result in a rescheduled appointment to treat the following patients in a timely manner.

Extended Payments: For certain procedures not covered by the insurance, extended payment plans may be available.

Credit Cards: We accept all forms of credit cards for your convenience.

I have read, understand and agree with this Financial Policy.

_____ _____

Signature of Patient or Responsible Party *Date*

THOMAS M. LOE D.D.S.
10320 VENICE BOULEVERD
CULVER CITY, CALIFORNIA 90232
TELEPHONE (310)838-3177

LOCAL ANESTHESIA CONSENT FORM

THIS CONSENT FORM IS DESIGNED TO MAKE YOU AWARE OF THE RISK INVOLVED WITH LOCAL ANESSTHESIA. THE RISK INCLUDE, BUT ARE NOT LIMITED TO:

1. THERE ARE RISK OF ANESTHESIA THAT MAY AFFECT YOUR BODY, SUCH AS DIZZINESS, NAUSEA, VOMITING, ACCELERATED HEARTH RATE, SLOW HEARTHRATE, OR VARIOUS TYPES OF ALLERGIC REACTIONS. ANY OR ALL OF THESEMAY REQYUIRE ADDITIONAL MEDICAL. MANAGEMENT OR HOSPITALIZATION.
2. RESTRICTED MOUTH OPENING DURING RECOVERRY, SOMETIMES RELATED TO MUSCLE SORENESS AT THE SITE OF THE INJECTION REQUIRING PHYSICAL THERAPY.
3. LOCAL ANESTHESIA MAY CAUSE PROLONGED NUMBNESS, THAT IN SOME PATIENTS MAY RESULT IN INJURY FROM BITING OR CHEWING AN AREA SUCH AS (LIP, CHEEK, OR TONGUE THAT HAS RECEIVED THE LOCAL ANESTHESIA.
4. INJURE TO NERVES THAT CAN RESULT IN PAIN, NUMBNESS, TINGLIN, OR OTHER SENSORY DISTURBANCES TO THE CHIN, LIP CHEEK, GUMS OR TONGUE. THIS MAY PERSIST FOR SEVERAL WEEKS, MONTHS, OR RARELY, BE PERMANENT.
5. LOCAL ANESTHESIA IS ADMINISTERED WITH A VERY SMALL FINE NEEDLE. IN VERY RARE INSTANCES THESE NEEDLES MAY BREAK OFF AND BE LOADGED IN SOFT TISSUE, ESPECIALLY WHEN A PATIENT MOVES WHILE ANESTHESIA IS BEING GIVEN.

PLEASE ASK THE DENTIST IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM. DO NOT INITIAL OR SIGN ANY BLNK IF YOU HAVE NOT HAD YOUR QUESTIONS ANSWERED.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT AND HAVE DISCUSSED ALL QUESTIONS OR CONCERNS THAT I MAY HAVE REGARDING LOCAL NESTHESIA.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

_____ _____

DOCTOR SIGNATURE DATE