HEALTH HISTORY

Jared B. Antrobus, D.D.S., Inc. **6000 Fairway Drive Suite #10** **Rocklin, California 95677**

Patient's Name Age Date of Birth Height Weight Date

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? ....Y N
2. Has there been any change in your general health in the past year?....................................Y N
3. Date of last physical exam ___________________________
4. Name of Physician:_________________________________
5. Physician's Phone Number:__________________________
6. Are you now under a physician's care for a particular problem? ....Y N
7. Have you **ever** had any serious illnesses, Operations (SURGERIES) or hospitalizations? If so, describe: ....Y N

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6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? ....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ....Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?...Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?............Y N
   - G. Liver Disease (Jaundice, Hepatitis)?......................Y N
   - H. Kidney Disease?...Y N
   - I. Diabetes?..Y N
   - J. Thyroid Disease (Goiter)?.......................................Y N
   - K. Arthritis?...Y N
   - L. Stomach Ulcers or Colitis?.....................................Y N
   - M. Glaucoma?...Y N
   - N. Osteoporosis?..Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?..................Y N
   - P. Radiation (X-ray) treatment for Cancer? ....Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?......Y N
   - R. Sinus or Nasal problems?.......................................Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ....Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?..Y N
   - B. Anticoagulants (Blood Thinners)?...........................Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications?.........................Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ....Y N
   - F. Tranquilizers? ....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ....Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ....Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____________________________________

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8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ....Y N
   - B. Penicillin or other antibiotics? ....Y N
   - C. Sedatives, Barbiturates?..Y N
   - D. Aspirin or Ibuprofen?..Y N
   - E. Codeine or other pain killers? ....Y N
   - F. Latex or Rubber products? ....Y N
   - G. Metal of any kind?..Y N
   - H. Chemicals or jewelry (rash or sensitivity)?.............Y N
   - I. Food products?...Y N
   - J. Other allergies or reactions? Please list................Y N

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9. Do you smoke or chew Tobacco?..................................Y N
   How much per day? _________
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?...Y N
11. Have you had any serious problems associated with any previous dental treatment?......................................Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia?.........Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ....Y N
14. Do you wish to talk to the doctor privately about anything? ....Y N
15. Have you ever had a bone density scan? ....Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?..Y N
    - B. Are you nursing?...Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

____________________	____	______________________
Date	Signature of Person Completing Health History	Doctor's Initials

Write your Dentist's full name: ______________________________

Who referred you to this office? ______________________________

Chief Dental Complaint: ____

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I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____________ Patient's Signature: _______________________________________

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ____

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Significant findings from questions or oral interview: ____

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Dental Management Considerations: ____

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Date: __________________ Dentist's Signature: _______________________________________

Medical History Update:

Date	Comments	Signature

Jared B. Antrobus, D.D.S., Inc.

PATIENT REGISTRATION FORM

Patient's Name: ___________________________________ Today's Date: ___/___/___
Date of Birth: ___/___/___ Social Security Number: _______-_______-_________
Address: ____
City: _________________________ State: _________ Zip: ______________
Phone No. Home: (___) _____-_________Work: (___) ____-_________ Ext: ______
Cell: (___) ____-________ Your Occupation: ____________________________
Email: ___________________________ (will only be used for appointment related purposes)

Are you a Student? Full Time □; Part-Time □; No □
Relationship to person responsible for payment: Self□; Spouse□; Child□; Other□

If Different from Patient, Person Responsible for Payment:

Mother's Name: ______________________ Father's Name: ___________________________
DOB: ___/___/____ SSN: ____-____-_____ DOB: ___/___/____ SSN: ____-____-_______
Address: ______________________________ Address (if different): ______________________
City: ___________ State: _____ Zip:______ City:______________State:____ Zip:________
Phone No. Home: _____________________ Phone No. Home: _________________________
Work: _______________________________ Work: ___________________________________
Cell: Cell:

Please provide a copy of your insurance card or cards.

Primary Dental Insurance Co: ________________________________ Group No: ________
Subscriber/member name: __________________________________ Date of Birth: __/__/__
Social Security No./ID# _________________________Insurance Phone:______________
Insurance Address: ____

Secondary Dental Insurance Co: ____________________________Group No: ________
Subscriber/member name: __________________________________ Date of Birth: __/__/__
Social Security No./ID# _________________________Insurance Phone:______________
Insurance Address: ____

(If Applicable)
Medical Insurance Co: ________________________________ Group No: ____________
Subscriber/member name: ______________________________ Date of Birth:___/___/___
Social Security No./ ID#: __________________________Insurance Phone: ___________
Insurance Address: ____

I understand that I am responsible for paying all fees for treatment rendered. I understand that my insurance may only pay part of these fees. I understand that no contract exists between my insurance company and the Doctor. **Payment or insurance co-payment is to be rendered when services is provided.**

Signature of person responsible for payment: ______________________________

DENTAL INSURANCE

PAYMENT FOR SERVICES

At least partial reimbursement for dental treatment is often available through various dental insurance benefit plans. However, the treatment fee is your responsibility. You are responsible for any balance your insurance does not pay. Before treatment, read your dental and/or medical insurance policy or check with your insurance representative concerning your coverage. Your dentist's office has its own financial policies, so be sure to discuss payment arrangements prior to your dental appointment and make sure all parties fully understand these arrangements. The office's financial coordinator will be happy to answer any questions you have about fees and payment.

Sign: ___________________________ Date:___/___/____

Patient Consent Form: Use and Disclosure of Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my Protected Health Information (PHI) for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to extent that disclosures have been made in reliance upon my prior consent.

I hereby consent that photographs may be taken during my surgery to be used in a manner for medical programs developed on behalf of Jared B. Antrobus, DDS, Inc. I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond documentation for my chart.

Services are provided without regard of sex, race, color, religion, national origin, or disability.

Date: _______________ Patient Name: _____________________________

Patient Signature: __________________________

If applicable, Legal Guardian: ___________________________________

Copy: Patient, Patient's medical record

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