DISTINCTIVE DENTISTRY *of* CHARLOTTE

Patient's Name:_____ Nickname:_____ Age:_____

Name of Physician/and their specialty:_____/_____

Most recent physical examination:___/___/___ Purpose:_____

What is your estimate of your general health?: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD	Yes	No
01. hospitalization for illness or injury	☐	☐
02. an allergic reaction to		
aspirin, ibuprofen, acetaminophen, codeine	☐	☐
penicillin	☐	☐
erythromycin	☐	☐
tetracycline	☐	☐
sulfa	☐	☐
local anesthetic	☐	☐
fluoride	☐	☐
metals (nickel, gold, silver, _____)	☐	☐
latex	☐	☐
Any other medications _____		
03. heart problems, or cardiac stent within the last six months	☐	☐
04. history of infective endocarditis	☐	☐
05. artificial heart valve, repaired heart defect (PFO)	☐	☐
06. pacemaker or implantable defibrillator	☐	☐
07. artificial prosthesis (heart valve or joints)	☐	☐
08. rheumatic or scarlet fever	☐	☐
09. a high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11 . anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR >3.5)	☐	☐
13. emphysema, sarcoidosis	☐	☐
14. tuberculosis	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c = _____)	☐	☐
24. stomach & duodenal ulcer	☐	☐
25. digestive disorders (i.e. gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. glaucoma	☐	☐
29. contact lenses	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsions (seizures)	☐	☐
32. neurologic problems (attention deficit disorder)	☐	☐
33. viral infections and cold sores	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. STI/STD	☐	☐
37. hepatitis (type:_____)	☐	☐
38. HIV/AIDS	☐	☐
39. tumor, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy	☐	☐
42. emotional problems	☐	☐
43. psychiatric treatment	☐	☐
44. antidepressant medication	☐	☐
45. alcohol/street drug use	☐	☐
ARE YOU:		
46. presently being treated for any other illness	☐	☐
47. aware of a change in your health (I.e. fever, new cough)	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements	☐	☐
50. often exhausted or fatigued	☐	☐
51. experiencing frequent headaches	☐	☐
52. a smoker, smoked previously or use smokeless tobacco	☐	☐
53. FEMALE - taking birth control pills	☐	☐
54. FEMALE - pregnant	☐	☐
55. MALE - prostate disorders	☐	☐

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Please advise us in the future of any change in your medical history or any medications you may be taking.

HEALTH HISTORY

DISTINCTIVE DENTISTRY
of CHARLOTTE

Legal Name: Last Name _____ First Name _____ Mid Name _____	Date of Birth: ___/___/___ Sex _____
Social Security # ___-___-_____ Prefer to be called _____ Home Phone (____) - _____-_____	Cell Phone (____) - _____-_____
Home Address _____ City _____ State ____ Zip _____	Email _____
Marital Status _____ Patients/Guardians Employer _____	Occupation _____
Work Address _____ City _____ State ____ Zip _____	Work Phone (____) - _____-_____ Ext._____
Spouses: Last Name _____ First Name _____ Mid Name _____	Occupation _____
Spouses Employer _____	Work Phone (____) - _____-_____ Ext._____
Work Address _____ City _____ State ____ Zip _____	
Other family members that are patients here _____ _____	Who can we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION

Person we may contact in case of an emergency (Other than your family home)

Name _____		Relationship _____
Home Phone (____) - _____-_____	Cell Phone (____) - _____-_____	Work Phone (____) - _____-_____Ext. _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

As my dental care provider you may do the following with my permission

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail/answering machine	☐	☐
Leave messages on my cell phone voice mail	☐	☐
Leave messages on my work voicemail/answering machine	☐	☐

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to refuse to sign this document and that my treatment will not be conditioned on signing. Authorization is in effect until revoked.

Signature:_____ Date: _____

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Acknowledgment of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other: _____

_____

Prepared By _____

Signature _____

Date _____

ADDITIONAL INFORMATION