PEAK FAMILY DENTISTRY
DR. BILLIE ADAMS
General Dentistry ♦ Crowns & Veneers ♦ Cosmetic Dentistry ♦ Implants

MEDICAL HEALTH HISTORY pg. 1 (continued on reverse side)

ABOUT YOU

Name _____ Nickname _____
Social Security # _____ / _____ / _____ Birthdate _____ / _____ / _____
Street Address _____ Home Phone _____
City, State, Zip _____ / _____ / _____ Work Phone _____
Employer _____ Cell Phone _____
Occupation _____ Email _____
Marital Status _____ Name of Spouse _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____ Relationship _____
Work Phone _____ Cell Phone _____
Home Phone _____

PERSON RESPONSIBLE FOR YOUR BILL

Name _____
Billing Address _____
City _____ State _____ Zip _____

DENTAL INSURANCE

Dental Insurance Company _____ Insurance Phone # _____
Group # _____ ID # _____
Coverage Holder _____ Their Birthdate _____ / _____ / _____
Their Employer _____ Their Social Security # _____ / _____ / _____

MEDICAL HISTORY

Are you currently under the care of a physician? ..... YES _____ NO _____
If yes, please explain _____

_____

Name of Physician _____ Physician Phone # _____
Preferred Pharmacy Name _____ Phone # _____
Address _____
Are you currently taking any medications including non-prescription? ..... YES _____ NO _____
If yes, please list all medications and dosage _____

_____

Do you require antibiotics prior to dental treatment? ..... YES _____ NO _____
Have you had any total joint replacements? ..... YES _____ NO _____
If yes, where? *(ie: knee, hip, shoulder, etc)* _____ Replacement Date _____ / _____ / _____
Have you ever had an abnormal response to dental treatment or dental anesthetic? ..... YES _____ NO _____
Are you taking or previously taken bisphosphonate medications? ..... YES _____ NO _____
(i.e. Actonel, Bonivia, Fosomax, Zometa)

Are you allergic to any of the following?

Penicillin	YES _____ NO _____	Doxycycline	YES _____ NO _____		
Sulfa Drugs	YES _____ NO _____	Tetracycline	YES _____ NO _____		
Latex	YES _____ NO _____	Erythromycin	YES _____ NO _____		
Aspirin	YES _____ NO _____	Codeine	YES _____ NO _____		

Are you allergic to any other drugs or substances?

YES _____ NO _____
If yes, please list _____

_____

_____

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MEDICAL HEALTH HISTORY pg. 2

MEDICAL HISTORY

Do you have or have you ever had any of the following diseases or medical conditions?

Heart Attack?..... YES _____ NO _____, if yes, when? _____
Stroke?..... YES _____ NO _____, if yes, when? _____
Hepatitis? ..... YES _____ NO _____, if yes, when? _____

Acid Reflux / GERD	YES _____	NO _____	Heart Disease	YES _____	NO _____
Alcohol Dependency.....	YES _____	NO _____	Heart Murmur	YES _____	NO _____
Allergies/Seasonal	YES _____	NO _____	Heart Surgery	YES _____	NO _____
Anemia.....	YES _____	NO _____	High Blood Pressure	YES _____	NO _____
Arrhythmia	YES _____	NO _____	HIV / AIDS.....	YES _____	NO _____
Arthritis.....	YES _____	NO _____	Kidney Disease	YES _____	NO _____
Artificial Heart Valve	YES _____	NO _____	Liver Disease.....	YES _____	NO _____
Asthma.....	YES _____	NO _____	Low Blood Pressure	YES _____	NO _____
Bleeding Disorder	YES _____	NO _____	Lupus.....	YES _____	NO _____
Bronchitis	YES _____	NO _____	Osteoporosis	YES _____	NO _____
Cancer	YES _____	NO _____	Pacemaker / Defibrillator.....	YES _____	NO _____
Depression/Anxiety	YES _____	NO _____	Rheumatic Fever	YES _____	NO _____
Diabetes.....	YES _____	NO _____	Seizures	YES _____	NO _____
Drug Dependency.....	YES _____	NO _____	Sinus Problems	YES _____	NO _____
Emphysema/COPD	YES _____	NO _____	Sleep Apnea	YES _____	NO _____
Glaucoma	YES _____	NO _____	Thyroid Problems	YES _____	NO _____
Headaches/Migraines.....	YES _____	NO _____	Tuberculosis.....	YES _____	NO _____
Heart Defect.....	YES _____	NO _____	Ulcers / Colitis	YES _____	NO _____

WOMEN ONLY

Are you pregnant or breast feeding?...YES _____ NO _____ Due Date _____ / _____ / _____
Are you using Birth Control?.....YES _____ NO _____

DISCLAIMER

Although unlikely, there are certain inherent risks and potentially dangerous outcomes in any treatment plan or procedure. I understand the following potential outcomes of treatment: pain, swelling, infection, numbness, bleeding, damage to teeth, crowns or bridges, sinus communication and instrument separation. I understand that I am financially responsible for all fees including any collection costs, attorney costs, and or any court costs associated with the payment of fee for service. I certify that I have read and understand the above. I will not hold my dentist, or any other member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient or Responsible Party *Date*

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand this information can and will be used to: **1.) Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly. 2.) Obtain payment from third party payers for my health care services. 3.) Conduct normal health care operations such as quality assessment and improvement activities.** I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices, and that I may contact this office to obtain a current copy of the practices. I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the office is not required to agree to my requested restrictions, but if the office does not agree then it is bound to abide by such restrictions.

_____ _____
Patient Name *Relationship to Patient*

_____ _____
Signature *Date*