

# ADULT MEDICAL AND DENTAL HISTORY



Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_ Birth Date \_\_\_\_\_

## MEDICAL HISTORY

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 under a physician's care now?  yes  no If yes, please explain \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  yes  no If yes, please explain \_\_\_\_\_

Have you ever had a serious head or neck injury?  yes  no If yes, please explain \_\_\_\_\_

Are you taking any medications, pills, or drugs?  yes  no If yes, please explain \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  yes  no If yes, please explain \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  yes  no If yes, please explain \_\_\_\_\_

Are you on a special diet?  yes  no If yes, please explain \_\_\_\_\_

Do you use tobacco?  yes  no If yes, please explain \_\_\_\_\_

Do you use controlled substances?  yes  no If yes, please explain \_\_\_\_\_

Women, are you:

Pregnant/Trying to get pregnant?  yes  no Taking oral contraceptives?  yes  no Nursing?  yes  no

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs

Other, please explain \_\_\_\_\_

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

AIDS/HIV Positive	<input type="radio"/> yes <input type="radio"/> no	Cortisone Medicine	<input type="radio"/> yes <input type="radio"/> no	Hemophilia	<input type="radio"/> yes <input type="radio"/> no	Radiation Treatments	<input type="radio"/> yes <input type="radio"/> no
Alzheimer's Disease	<input type="radio"/> yes <input type="radio"/> no	Diabetes	<input type="radio"/> yes <input type="radio"/> no	Hepatitis A	<input type="radio"/> yes <input type="radio"/> no	Recent Weight Loss	<input type="radio"/> yes <input type="radio"/> no
Anaphylaxis	<input type="radio"/> yes <input type="radio"/> no	Drug Addiction	<input type="radio"/> yes <input type="radio"/> no	Hepatitis B or C	<input type="radio"/> yes <input type="radio"/> no	Renal Dialysis	<input type="radio"/> yes <input type="radio"/> no
Anemia	<input type="radio"/> yes <input type="radio"/> no	Easily Winded	<input type="radio"/> yes <input type="radio"/> no	Herpes	<input type="radio"/> yes <input type="radio"/> no	Rheumatic Fever	<input type="radio"/> yes <input type="radio"/> no
Angina	<input type="radio"/> yes <input type="radio"/> no	Emphysema	<input type="radio"/> yes <input type="radio"/> no	High Blood Pressure	<input type="radio"/> yes <input type="radio"/> no	Rheumatism	<input type="radio"/> yes <input type="radio"/> no
Arthritis/Gout	<input type="radio"/> yes <input type="radio"/> no	Epilepsy or Seizures	<input type="radio"/> yes <input type="radio"/> no	High Cholesterol	<input type="radio"/> yes <input type="radio"/> no	Scarlet Fever	<input type="radio"/> yes <input type="radio"/> no
Artificial Heart Valve	<input type="radio"/> yes <input type="radio"/> no	Excessive Bleeding	<input type="radio"/> yes <input type="radio"/> no	Hives or Rash	<input type="radio"/> yes <input type="radio"/> no	Sexually Transmitted Disease	<input type="radio"/> yes <input type="radio"/> no
Artificial Joint	<input type="radio"/> yes <input type="radio"/> no	Excessive Thirst	<input type="radio"/> yes <input type="radio"/> no	Hypoglycemia	<input type="radio"/> yes <input type="radio"/> no	Shingles	<input type="radio"/> yes <input type="radio"/> no
Asthma	<input type="radio"/> yes <input type="radio"/> no	Fainting Spells/Dizziness	<input type="radio"/> yes <input type="radio"/> no	Irregular Heartbeat	<input type="radio"/> yes <input type="radio"/> no	Sickle Cell Disease	<input type="radio"/> yes <input type="radio"/> no
Blood Disease	<input type="radio"/> yes <input type="radio"/> no	Frequent Cough	<input type="radio"/> yes <input type="radio"/> no	Kidney problems	<input type="radio"/> yes <input type="radio"/> no	Sinus Trouble	<input type="radio"/> yes <input type="radio"/> no
Blood Transfusion	<input type="radio"/> yes <input type="radio"/> no	Frequent Diarrhea	<input type="radio"/> yes <input type="radio"/> no	Leukemia	<input type="radio"/> yes <input type="radio"/> no	Spina Bifida	<input type="radio"/> yes <input type="radio"/> no
Breathing Problem	<input type="radio"/> yes <input type="radio"/> no	Frequent Headaches	<input type="radio"/> yes <input type="radio"/> no	Liver Disease	<input type="radio"/> yes <input type="radio"/> no	Stomach/Intestinal Disease	<input type="radio"/> yes <input type="radio"/> no
Bruise Easily	<input type="radio"/> yes <input type="radio"/> no	Genital Herpes	<input type="radio"/> yes <input type="radio"/> no	Low Blood Pressure	<input type="radio"/> yes <input type="radio"/> no	Stroke	<input type="radio"/> yes <input type="radio"/> no
Cancer	<input type="radio"/> yes <input type="radio"/> no	Glaucoma	<input type="radio"/> yes <input type="radio"/> no	Lung Disease	<input type="radio"/> yes <input type="radio"/> no	Swelling of Limbs	<input type="radio"/> yes <input type="radio"/> no
Chemotherapy	<input type="radio"/> yes <input type="radio"/> no	Hay Fever	<input type="radio"/> yes <input type="radio"/> no	Mitral Valve Prolapse	<input type="radio"/> yes <input type="radio"/> no	Thyroid Disease	<input type="radio"/> yes <input type="radio"/> no
Chest Pains	<input type="radio"/> yes <input type="radio"/> no	Heart Attack/Failure	<input type="radio"/> yes <input type="radio"/> no	Osteoporosis	<input type="radio"/> yes <input type="radio"/> no	Tonsillitis	<input type="radio"/> yes <input type="radio"/> no
Cold Sores/Fever Blisters	<input type="radio"/> yes <input type="radio"/> no	Heart Murmur	<input type="radio"/> yes <input type="radio"/> no	Pain in Jaw Joints	<input type="radio"/> yes <input type="radio"/> no	Tuberculosis	<input type="radio"/> yes <input type="radio"/> no
Congenital Heart Disorder	<input type="radio"/> yes <input type="radio"/> no	Heart Pace Maker	<input type="radio"/> yes <input type="radio"/> no	Parathyroid Disease	<input type="radio"/> yes <input type="radio"/> no	Tumors or Growths	<input type="radio"/> yes <input type="radio"/> no
Convulsions	<input type="radio"/> yes <input type="radio"/> no	Heart Trouble/Disease	<input type="radio"/> yes <input type="radio"/> no	Psychiatric Care	<input type="radio"/> yes <input type="radio"/> no	Ulcers	<input type="radio"/> yes <input type="radio"/> no
						Yellow Jaundice	<input type="radio"/> yes <input type="radio"/> no

Have you ever had any serious illness not listed above?  yes  no If yes, please explain: \_\_\_\_\_

(continued on the back)

## DENTAL HISTORY

What is the reason for your visit? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ When were your last x-rays? \_\_\_\_\_

Are you having any pain or sensitivity? \_\_\_\_\_

Does food tend to become caught between your teeth? \_\_\_\_\_

Do you have any sores or lumps in or near your mouth? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_

Have you ever experienced any of the following problems in your jaw:

- Clicking    Headaches    Difficulty opening or closing    Pain (joint, ear, side of face)

Have you ever had:

- Braces    Oral Surgery    Gum Treatment    Night Guard    Bite Adjustment    TMJ Treatment

Are you satisfied with the appearance of your teeth? \_\_\_\_\_

Have you ever had an upsetting experience in the dental office? \_\_\_\_\_

Comments:

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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 \_\_\_\_\_ Date \_\_\_\_\_



## INFORMED CONSENT FOR OPALESCENCE ® BOOST TEETH WHITENING TREATMENT

### DESCRIPTION OF PROCEDURE

The Opalescence ® Boost teeth whitening system is Ultradent, Inc.'s professional teeth whitening product. The Opalescence ® Boost teeth whitening system employs a hydrogen peroxide-based bleaching gel. This whitener comes prepackaged as two individual components that are mixed at the time of application. The procedure usually takes around an hour and a half from start to finish. Each bleaching session is broken down into two individual applications of the Opalescence ® Boost teeth whitener, with the duration of each application being 20 minutes applied one after the other on the same day.

### VARIATION IN RESULTS

Treatment results may vary or regress depending on the patient and a variety of circumstances. **The achievement of a certain shade is unpredictable and cannot be guaranteed.** Whitening treatments are not intended to lighten artificial teeth, caps, crowns, veneers, or composites and teeth with multiple colorations, bands, splotches or spots may need multiple treatments or may not whiten at all.

### RELAPSE

After treatment, it is natural for teeth to regress to their original shade. This progression tends to be gradual but can be accelerated if teeth are exposed to various staining agents. The results are not permanent and secondary, repeat, or take-home treatments may be needed to maintain the lightest tooth shade achieved after treatment. Refraining from consuming any dark colored substances that could discolor your teeth for the first 48 hours after treatment is recommended. Some examples of dark substances are coffee, tea, colas, all tobacco products, mustard or ketchup, red wine, soy sauce, berries, and red sauces.

### TOOTH SENSITIVITY/PAIN

After treatment, patients may experience some tooth sensitivity or pain. This is normal and is usually mild, but can be worse in susceptible individuals. People with increased sensitivity or dental conditions that allow dispersion of the gel into the tooth may experience increased or prolonged tooth sensitivity or pain.

### RISKS

In-office whitening treatments are considered safe but are not without risks. Please ask your dental professional to discuss with you any specific concerns you may have about Opalescence ® Boost Teeth Whitening System.

### CONSENT

I have been given this information so that I can make an informed decision for myself. By signing this document I am indicating that I have read and understood the above information and am giving my permission for the Opalescence ® Boost Teeth Whitening Treatment to be performed on me.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_



## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

**Patient Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and certifications

I acknowledge that, upon request, I can review the *Notice of Privacy Practices* which contains a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* and that I can obtain a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

**Signature of Patient, Parent of Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_