ADULT MEDICAL AND DENTAL HISTORY

MERRY
Dental Care Center, PA

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? O yes O no If yes, please explain _____

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

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

Are you taking any medications, pills, or drugs? O yes O no If yes, please explain _____

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

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

Are you on a special diet? O yes O no If yes, please explain _____

Do you use tobacco? O yes O no If yes, please explain _____

Do you use controlled substances? O yes O no If yes, please explain _____

Women, are you:

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

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Sulfa Drugs

O Other, please explain _____

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

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

Have you ever had any serious illness not listed above? O yes O 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:

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

Have you ever had:

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

Are you satisfied with the appearance of your teeth? _____

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

Comments:

_____

_____

_____

_____

_____

_____

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 _____

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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** _____

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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 _____