WAIMĀNALO HEALTH CENTER

Patient Registration: ADULT

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please check one)*
☐ Male ☐ Female

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Gender Identity
☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Chose not to disclose

Sexual Orientation
☐ Lesbian, Gay or Homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Chose not to disclose

Home Address	City	State	Zip Code
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone ( )	☐ Cell Phone ( )	☐ Day Phone ( )	☐ E-Mail Address

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Patient Portal *is WHC's latest technology that allows you to schedule and view appointments, request medication refills and see lab results, communicate with your health care team, ask questions about your bill and request your health record.*

Are you enrolled into Patient Portal? ☐ Yes ☐ No **If No, do you need assistance to enroll?** ☐ Yes ☐ No

Do you have an Advance Directive?
(Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond): ☐ Yes ☐ No

Housing Status: ☐ Not Homeless ☐ Homeless: ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Farmer Status: ☐ N/A ☐ Seasonal ☐ Migrant

Active Military or Veteran: ☐ Yes ☐ No

Race (pick one below that best describes you):

☐ African American/Black ☐ White ☐ Chinese ☐ Chuukese ☐ Filipino ☐ Guamanian
☐ Japanese ☐ Korean ☐ Laotian ☐ Marshallese ☐ Micronesian ☐ Native American
☐ Native Hawaiian ☐ Portuguese ☐ Puerto Rican ☐ Samoan ☐ Tongan ☐ Vietnamese
☐ Other Asian ☐ Other Pacific Islander ☐ All Other (please specify): _____

GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Home Address	City	State	Zip Code

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone ( )	☐ Cell Phone ( )	☐ Day Phone ( )	☐ E-Mail Address

Patient Registration: ADULT

Patient Name: _____ MRN: _____

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**

PATIENT EDUCATION / EMPLOYMENT			
Employer/School Name:	☐ Employed ☐ Unemployed	☐ Student	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Retired
Occupation:	**Family Size** (includes self, spouse, & children under 18): _____	**Family Income:** $ _____	☐ Monthly ☐ Annual

_____ Initials I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or organization in order to process claims on my behalf. I authorize payment of medical benefits to WHC for services rendered.

_____ Initials I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials I authorize WHC to call my residence and/or cellular phone for an appointment reminder. If I am not available, I also authorize WHC to communicate the reminder by leaving a message which will identify the call coming from WHC and will include the date and time of my appointment.

_____ Initials I received the Privacy Practice Notice.

_____ Patient's Signature _____ Date Signed

_____ Guarantor's Signature _____ Date Signed

FOR OFFICE USE ONLY					
MEDICAL SERVICES – Record #_____					
Pt Status Type: ☐ Scheduled ☐ Active	☐ Inactive ☐ Non-WHC Active ☐ Dental Patient Only	**Valid ID:**	☐ Scan ID ☐ Update NG Pt Picture	**Insurance:**	☐ Scan Card ☐ Update Info/Card
Collected By: _____ Date: _____		Entered By: _____ Date: _____			
DENTAL SERVICES – Person #_____					
Pt Status Type: ☐ Scheduled ☐ Active	☐ Inactive ☐ Non-WHC Active ☐ Dental Patient Only	**Valid ID:**	☐ Scan ID ☐ Update NG Pt Picture	**Insurance:**	☐ Scan Card ☐ Update Info/Card
Collected By: _____ Date: _____		Entered By: _____ Date: _____			

Patient Registration: INSURANCE

Patient Name: _____ MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

PRIMARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

WAIMĀNALO HEALTH CENTER

CONSENT FOR CARE

I,_____, the undersigned, hereby give Waimānalo Health Center my consent and permission to obtain historical information, perform physical examinations, order diagnostic tests and give such treatment as the Center physicians deem appropriate for my physical and/or mental health. I understand that this consent is for, but not limited to, obtaining detailed medical and social/psychiatric histories, performance of examinations of mouth, genitals, rectum and ears, repair of minor cuts, tuberculin skin tests, injection of local anesthetics and medications (such as insulin, epinephrine, etc.), injection of immunizations, and all other ordinary medical office procedures.

I understand that for major surgery or other major procedures (such as incision and drainage of abscesses, biopsies or insertion of such devices as an IUD or Norplant) special explanations will be made to me and special permission obtained from me or from an adult family member if I am physically or mentally impaired from giving such consent. In cases of emergency I hereby give permission for the rendering of all such medical services deemed necessary to stabilize my condition if I am physically or mentally impaired and an adult family member is not readily available.

I understand that this consent extends to diagnostic tests and services rendered at the Waimānalo Health Center clinic, designated laboratories, X-ray facilities, emergency rooms, offices of specialists, and hospitals by Center physicians as deemed necessary for medical care.

This consent is for the ongoing health care of myself until I withdraw from the Waimānalo Health Center and is given voluntarily. By my signature I hereby certify that I am of legal age (18 years old or older) or am an emancipated minor by the definition of State laws.

I understand that I am not consenting to any experimental procedures nor to any tests solely for the purpose of research or scientific study. My photograph may be used for medical records and for publicizing the Waimānalo Health Center.

I certify that I have read the above (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

_____

_____

_____

_____

Patient or Legal Guardian Signature

_____

Date

WAIMĀNALO HEALTH CENTER

PATIENT RIGHTS AND RESPONSIBILITIES

WAIMĀNALO HEALTH CENTER (WHC) ENCOURAGES PATIENTS AND THEIR `OHANA TO KNOW & EXERCISE THEIR RIGHTS AND RESPONSIBILITIES

As a Waimānalo Health Center Patient, you have the right to:	*As a Waimānalo Health Center Patient, your responsibilities are to:*
❖ Be treated with courtesy, dignity and respect—regardless of race, color, sex, age national origin, or beliefs. ❖ Be seen in a safe, secure environment and in a timely manner. ❖ Know the name of your health provider, and the names and positions of staff you encounter. ❖ Be informed of your condition and understand the treatments. ❖ Refuse treatment at any time and to be informed of the risks of the refusal of treatment. ❖ Be informed of the reasons for tests and treatments and to receive the results in a timely manner. ❖ Refuse to sign consent forms until you understand what you are signing. ❖ Refuse to participate in educational or experimental activities by choice. ❖ Participate in all decisions regarding your care as stated within the law. ❖ Identify a person whom you would like to make decisions for you when you are unable to do so, using the Advance Care Directives. ❖ Be referred for emergency or specialized services not provided by WHC. ❖ Have your health information protected and held in confidentiality. ❖ Obtain explanations of monies that you owe to the health center on your bill. ❖ Request and receive copies of your medical records at a small fee.	❖ Treat all persons in the health center with courtesy, dignity and respect at all times. ❖ Provide accurate information for registration, billing, payment, informed consents and changes that occur, including any changes in your address, phone number, insurance, and or any other contact information ❖ Provide information regarding your concerns to a patient advocate or may request to speak with the Dental Director, Chief Performance and Compliance Officer, Chief Medical Director or Chief Executive Officer. ❖ Be on time for scheduled appointments and to cancel appointments before the scheduled appointment, according to Waimānalo Health Center policies. This includes any specialty or referral appointments made for you. ❖ Provide requested information for your medical history accurately including past illnesses, medications, allergies, hospitalizations, family and social histories. ❖ Ask questions if you are unclear about papers and information that you and your provider have agreed upon. ❖ Keep your personal belongings in a safe place. Lost and/or stolen personal items are not the responsibility of Waimānalo Health Center.

Waimānalo Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you need language assistance, services free of charge, are available to you. Call 808-259-7949.

WE WISH TO OFFER YOU THE BEST HEALTH CARE POSSIBLE AND APPRECIATE YOUR INPUT AS A HIGHLY VALUED TEAM PLAYER.

I have reviewed and received a copy of the above Patient Rights & Responsibilities. I understand that if I or any of my family members do not follow the rules, I may not be able to receive care at this health center.

_____ _____

Print Name of Patient Date

_____

Patient or Legal Guardian Signature

WAIMĀNALO HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Responsibilities:
Waimānalo Health Center (WHC) is required by law to maintain the privacy of your health information; provide this notice that describes the ways we may use and share your health information; and follow the terms of the notice currently in effect.

Privacy Promise: WHC understands that your health information is personal and protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. You have the right to be notified if a breach of protected health information occurs.

Uses and Disclosures of Health Information Permitted by Law: The following categories describe the ways that the WHC may use and disclose your health information. Some health records including confidential communications with a mental health professional, some substance abuse treatment records, some genetic results, and some health information of minors, may have additional restrictions for use and disclosure under state and federal laws. Your health information will be used or disclosed only for the following purposes:

When you receive care from WHC, we may use your health information for treating you, billing services, and conducting our normal business known as health care operations. Examples of how we use your information include:

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. We may call you by name in the waiting room when the provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Payment: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or another third party. We may contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. We may disclose protected health information to other health care providers or third parties to assist in billing and collection efforts. You have the right to restrict disclosure of your protected health information to a health plan when you pay out of pocket in full for health care services.

Health Care Operations: We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

Individuals Involved in your Care or Payment of your Care: We may disclose your health information to a spouse, family member, close personal friend, or any individual identified by you if we obtain your agreement. You will have the opportunity to identify this person or to object to our disclosing information to them.

Business Associates: WHC may use or disclose health information about you with people who contract with us to provide goods and services used in your treatment or for hospital operations. Examples include copy services, consultants, interpreters, and health transcriptionists. The WHC requires these contractors to protect the confidentiality of your health information as we do.

Research: Under certain circumstances, we may use and disclose your health information for research purposes. Research projects are subject to a special review process that evaluates uses of health information; trying to balance the research needs with the need for patient privacy. Before we use or disclose health information for research, the project will have to be approved through this review process.

Fundraising: We may contact you to provide information about WHC sponsored activities, including fundraising programs and events. We would only use contact information, such as phone number and the dates you received treatment or services at WHC. Please inform us if you do not want us to contact you for these fundraising efforts.

Health Care Communications: To identify health-related services and products that may benefit you and then contact you about the services and products.

Deceased Individuals: We may release medical information to a coroner, medical examiner, or funeral director as necessary for them to carry out their responsibilities.

Organ Procurement Organizations: We may release your health information to organizations that handle organ procurement or organ, eye, or tissue transplants or to an organ donation bank, as required and necessary to facilitate organ or tissue donation and transplants.

Public Health Activities: WHC may use or disclose your health information with public health authorities in charge of preventing or controlling disease, injury, or disability. For example, the WHC is required to report infectious diseases to the Hawaii Department of Health; billing practices may be audited by the Hawaii State Auditor; records are subject to review by the Secretary of Health and Human Services; and the Federal Food and Drug Administration (FDA) to ensure product safety.

Workers Compensation: WHC may use or disclose health information about you for workers compensation or similar programs that provide benefits for work-related injuries or illnesses.

Judicial and Administrative Proceedings: In the course of a judicial or administrative proceeding in response to a legal order or other lawful purpose.

Threat to Health and Safety: We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of others.

Law Enforcement Officials: Specialized Government Functions: We may disclose information to the police or other law enforcement officials as required by law or in compliance with a court order. We may disclose information to military or veterans' authorities about Armed Forces personnel, under certain circumstances. We may also disclose information to authorized federal officials for purposes of lawful intelligence, counter-intelligence, and other national security activities.

All other users and disclosures, not described in this notice, require signed authorization. You may revoke your authorization at any time with a written statement submitted to Health Information.

Specially Protected Health Information: Unless otherwise required or permitted under law, disclosure of the following protected health information, outside our health center, requires your specific consent:

- AIDS/HIV information
- Mental health and mental illness records including psychotherapy notes
- Drug addiction and alcoholism (substance abuse) treatment records

Your individual Rights: You have the following rights concerning your health information. A request to exercise any of these rights must be made in writing to the Chief Performance and Compliance Officer and/or the Compliance Specialist.

Right to Alternative Communications: You have the right to request that WHC communicate with you in a certain manner. For example, you may ask that WHC contact you only at work, or a different address than your home address. You may request this during registration.

Right to Inspect and or Copy: You have the right to inspect and obtain copies of your health information. Usually, this includes health and billing records. *It does not include psychotherapy notes, or information we put together to prepare for legal action, and certain laws relating to laboratories.*
To obtain a copy of your health information, please submit a request in writing to the Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services from your request.

We may deny your request to inspect and copy your records in certain very limited circumstances. We will notify you in writing if your request has been denied and explain how you may appeal the decision. In certain limited situations, we will have to deny you access and you will not have the right to appeal that decision.

Right to Amend: If you think that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. You must provide a reason for the amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create.
- Is not part of the health information kept by our facility.
- Is not part of the information that you are allowed to inspect.
- Is accurate and complete.

Right to Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made. This accounting will not include disclosures:

- For treatment, payment, or health care options
- To persons involved in your care or for notification purposes
- Incidental to an otherwise permitted use or disclosure
- To correctional institutions or other law enforcement officials
- As part of a limited data set
- For national security or intelligence purposes
- For any use or disclosure that you specifically authorized or requested

You request must state a time period, which may not be longer than 6 years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures within 30 days of your request, or notify you if we are unable to have the list within 30 days and by what date we can have the list; but this date will not exceed 60 days from the date you made the request.

Right to Request Special Restrictions: You have the right to request special restrictions on sharing of your health information. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care. We are not required to agree to your request for restrictions if we are unable to comply or believe it will negatively affect the care we provide for you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, disclosure of specific information to your spouse.

Right to Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time. Copies of your current Notice are available from our front desk staff.

Changes to this Notice: We reserve the right to change our privacy practices as described in this Notice at any time. Except when required by law, we will write and make available upon request a new Notice before we make any changes in our privacy practices. The privacy practices in the most current Notice will apply to information we already have about you as well as any information we receive in the future. The Notice will contain an effective date.

Contact Us: If you would like further information about your privacy rights, are concerned that your privacy rights have been violate, or disagree with a decision that we made about access to your health information, contact the Chief Performance and Compliance Officer at (808) 954-7156 and Compliance Specialist at (808) 954-7166.

All complaints must be submitted in writing. We will investigate all complaints and will not retaliate against you for filing a complaint with the Office of Civil Rights of the U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Waimānalo Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you need language assistance, services free of charge, are available to you. Call 808-259-7949.

I, _____, have read and/or received a copy of the Waimanalo Health Center's Notice of Privacy Practices.

Patient or Legal Guardian Signature	Print Name (if not the Patient Signature)	Date

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent Infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments:_____