



PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth																														
Legal Sex (Please CHECK ONE)* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose <small>*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.</small>																																		
Physical 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: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Day Phone <input type="checkbox"/> E-Mail Address																																		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Do You Need An Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____																															
Housing Status: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Homeless: <input type="checkbox"/> Doubling Up <input type="checkbox"/> Shelter <input type="checkbox"/> Street, Beach, Etc. <input type="checkbox"/> Transitional <input type="checkbox"/> Unreported																																		
Ethnicity: <input type="checkbox"/> Chicano <input type="checkbox"/> Mexican American <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Not Reported <input type="checkbox"/> Mexican <input type="checkbox"/> Spanish (Or another Hispanic, Latino or Spanish Origin)		Farmer Status: <input type="checkbox"/> N/A <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal Active Military or Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No																																
Race (CHECK ONE below that best describes you): <table><tr><td><input type="checkbox"/> Native Hawaiian</td><td><input type="checkbox"/> Fijian</td><td><input type="checkbox"/> Chuukese</td><td><input type="checkbox"/> Filipino</td><td><input type="checkbox"/> Portuguese</td><td><input type="checkbox"/> White</td></tr><tr><td><input type="checkbox"/> Other Pacific Islander</td><td><input type="checkbox"/> Marshallese</td><td><input type="checkbox"/> I-Kiribati</td><td><input type="checkbox"/> Chinese</td><td><input type="checkbox"/> Puerto Rican</td><td><input type="checkbox"/> Chamorro</td></tr><tr><td><input type="checkbox"/> Samoan</td><td><input type="checkbox"/> Micronesian</td><td><input type="checkbox"/> Kosraean</td><td><input type="checkbox"/> Japanese</td><td><input type="checkbox"/> Other Asian</td><td><input type="checkbox"/> African American/Black</td></tr><tr><td><input type="checkbox"/> Tahitian</td><td><input type="checkbox"/> Palauan</td><td><input type="checkbox"/> Yapese</td><td><input type="checkbox"/> Vietnamese</td><td><input type="checkbox"/> Asian Indian</td><td><input type="checkbox"/> Native American</td></tr><tr><td><input type="checkbox"/> Tongan</td><td><input type="checkbox"/> Pohnpeian</td><td><input type="checkbox"/> Korean</td><td><input type="checkbox"/> Laotian</td><td colspan="2"><input type="checkbox"/> All Other (Please specify): _____</td></tr></table>					<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Fijian	<input type="checkbox"/> Chuukese	<input type="checkbox"/> Filipino	<input type="checkbox"/> Portuguese	<input type="checkbox"/> White	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Marshallese	<input type="checkbox"/> I-Kiribati	<input type="checkbox"/> Chinese	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Chamorro	<input type="checkbox"/> Samoan	<input type="checkbox"/> Micronesian	<input type="checkbox"/> Kosraean	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Tahitian	<input type="checkbox"/> Palauan	<input type="checkbox"/> Yapese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native American	<input type="checkbox"/> Tongan	<input type="checkbox"/> Pohnpeian	<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> All Other (Please specify): _____	
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Employer/School Name:		<input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Full-Time <input type="checkbox"/> Casual <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired																																
Occupation:		Family Size (includes self, spouse, & children under 18): _____	Family Income: \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual																															

PARENT/LEGAL GUARDIAN or GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____				
Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth
Physical 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: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Day Phone <input type="checkbox"/> Email Address				
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Do You Need An Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	
Employer Name:		<input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Full-Time <input type="checkbox"/> Casual <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired		
Occupation:		Family Size (includes self, spouse, & children under 18): _____	Family Income: \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	

Patient Registration

Patient Name: _____

MRN: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:		Relationship:
Home Phone	Work Phone	Cell Phone

PATIENT PORTAL

Patient Portal is WHC's latest technology that allows you to schedule and view appointments, request medication refills, 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

ADVANCE DIRECTIVES

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

MARKETING & PROMOTIONS

How did you hear about us? (Check all that apply)	<input type="checkbox"/> Family/Friends	<input type="checkbox"/> Mailer	<input type="checkbox"/> Web Search	<input type="checkbox"/> Banner
	<input type="checkbox"/> Social Media	<input type="checkbox"/> Print Ads	<input type="checkbox"/> Other (Please specify): _____	
How do you want to stay updated on services and classes? (Check all that apply)	<input type="checkbox"/> Email	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Patient Portal	
	<input type="checkbox"/> Text Message	<input type="checkbox"/> Mailer	<input type="checkbox"/> Other (Please specify): _____	

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 to process claims on my behalf. I authorize payment of 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 communicate via text, email, and phone call. Message & Data rates may apply. If I am not available, I give WHC consent to communicate a message which will identify the WHC service(s) and/or the date and time of my appointment(s). I may opt out at any time and will need to notify the Front Office.

Initials **MINOR:** I consent and authorize Waimānalo Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

Initials Patient was informed of [Waimānalo Health Center's Rights & Responsibilities](#). Information is available on WHC's website and patient may request a hard copy at any time.

Initials Patient was informed of [Waimānalo Health Center's Notice of Privacy Practices](#). Information is available on WHC's website and patient may request a hard copy at any time.

Patient or Legal Guardian's Signature

Date Signed

Guarantor's Signature

Date Signed

FOR OFFICE USE ONLY

Record # _____			
Pt Status Type:	<input type="checkbox"/> Inactive <input type="checkbox"/> Scheduled <input type="checkbox"/> Active	Valid ID:	<input type="checkbox"/> Scan ID <input type="checkbox"/> Update NG Pt Picture
	<input type="checkbox"/> Non-WHC Active <input type="checkbox"/> Dental Patient Only	Insurance:	<input type="checkbox"/> Scan Card <input type="checkbox"/> Update Info/Card
Collected By: _____		Entered By: _____	
Date: _____		Date: _____	

Patient Registration: INSURANCE

Patient Name: _____

MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION									
Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
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): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
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): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
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): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
Plan Name		Policy # / Subscriber #		Group #		Effective Date:		Expiration Date:	
Home Address				City		State		Zip Code	
Home Phone			Work Phone			Cell Phone			

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 LARC) 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.

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



APPOINTMENT KEEPING AGREEMENT

Patient Information

It is important to keep your medical appointment(s) and to be on time. At Waimānalo Health Center (WHC), our goal is to provide quality medical care in a timely manner. In our efforts to make your visit more comfortable and to minimize your wait time, we have updated and implemented the following policies and procedures.

A. Check-in Policy:

To ensure access and timeliness of medical care, the front office and medical team will inform you to arrive at your designated check-in time, to allow for registration and screening prior to your scheduled appointment time. You are encouraged to:

1. Call by 3:00 PM on the day prior to your appointment to notify us of any changes; and/or
2. If you may be late for your designated check-in time.

B. Late Arrival Policy

We understand that delays can occur, however, it is important to us to see all patients as timely as possible. Not arriving at your designated check-in time is considered late. Clock times on the WHC Front Desk computers will be used to validate ALL designated check-in times. If you arrive late for your appointment, you may experience one of the following:

1. You may be asked to wait until the provider is available.
2. You may be asked to reschedule your appointment for a later time on the same day or on a different day.
3. You may be offered an appointment with another provider on the same day, if available.
4. If no open appointments are available, you may choose to wait in case an opening arises – thought this is not guaranteed.
5. Kukui Clinic (Behavioral Health) Only: If you arrive late, you will be seen for the remainder of your scheduled appointment time.

C. Cancellation Policy

If you are not able to make your scheduled appointment, please call us at (808) 259-7948 by 3:00 PM on the day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 PM on Friday. Appointments are in high demand, and your early cancellation will give another person access to timely medical care.

1. If you are not able to speak to someone, please leave a message with your name, phone number, your appointment date/time and request for rescheduling or cancellation reason.
2. If you receive appointment text reminders, you may reply with an "X" to cancel your appointment.

D. No Show Policy:

All patients who miss three (3) appointments dates in a three-month period, will be considered a chronic no show. After the third missed appointment date, you will be placed on a "Same Day Only" status. You may return to a regular status at the end of the rolling three-month period.

Waimānalo Health Center is committed to providing exceptional care. Your help in keeping your appointments enables us to provide better and timelier care for you and all of our patients.

I have read and consent to these terms.

Print Patient Name

Print Legal Guardian Name

Relationship

Patient Signature
(Parent/Legal Guardian if under 18)

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:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
<div>LastFirstMiddle</div>			()		()	
Address:			City:		State: Zip:	
<div>Mailing address</div>						
Occupation:			Height: Weight:		Date of birth: Sex: M F	
SS# or Patient ID:			Emergency Contact:		Relationship: Home Phone: Cell Phone:	
					() () <i>Include area codes</i>	
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)						
Active Tuberculosis..... Yes No DK						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
Persistent cough greater than a 3 week duration..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
Cough that produces blood..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
Been exposed to anyone with tuberculosis..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
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.

<div>Yes No DK</div> <div>Do your gums bleed when you brush or floss? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Does food or floss catch between your teeth? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Is your mouth dry?..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you had any periodontal (gum) treatments? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you ever had orthodontic (braces) treatment? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Is your home water supply fluoridated? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you drink bottled or filtered water? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY</div> <div>Are you currently experiencing dental pain or discomfort? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>What is the reason for your dental visit today?</div> <div>How do you feel about your smile?</div>	<div>Yes No DK</div> <div>Do you have earaches or neck pains? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you have any clicking, popping or discomfort in the jaw? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you brux or grind your teeth? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you have sores or ulcers in your mouth? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you wear dentures or partials? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you participate in active recreational activities?..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Date of your last dental exam: What was done at that time?</div> <div>Date of last dental x-rays:</div>
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Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<div>Yes No DK</div> <div>Are you now under the care of a physician? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Physician Name: Phone: <i>Include area code</i></div> <div>()</div> <div>Address/City/State/Zip:</div> <div>Are you in good health? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Has there been any change in your general health within the past year? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If yes, what condition is being treated?</div> <div>Date of last physical exam:</div>	<div>Yes No DK</div> <div>Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If yes, what was the illness or problem?</div> <div>Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:</div> <div></div> <div></div> <div></div> <div></div>
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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?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: If yes, have you had any complications?					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began:					
Allergies - Are you allergic to or have you had a reaction to: Yes No DK			Yes No DK		
To all yes responses, specify type of reaction.					
Local anesthetics			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			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			Yes No DK		
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)					
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>					
Yes No DK			Yes No DK		
Cardiovascular disease:			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date:					
Hemophilia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/					
Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify:					
Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify:					
Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of infection:					
Kidney problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches/migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?					
Name of physician or dentist making recommendation:			Phone:		
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: _____

