

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I understand that if I decline to undergo treatment, delay treatment, or fail to keep my appointment(s), I accept that there may be permanent irreversible damage to my dental health.

_____ Please Initial

4. I agree to the use of anesthetics, sedatives and other medication, as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

**ACKNOWLEDGMENT OF
PRIVACY PRACTICES**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to :

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's 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 and receive a copy of 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 at the address on the front side of this sheet to obtain a current copy of the Notice of Privacy Practices.

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 health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Signature _____ Date _____

Dependent family members also covered by this acknowledgment: _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

ROBERT D. YOUNG, D.D.S. Health History Form

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

Address: _____ City: _____ State: _____ Zip: _____
Mailing Address

Occupation: _____ Date of Birth: _____ Sex: M or F (circle one)

Emergency Contact: _____ Relationship: _____ Home Phone: _____
 Cell Phone: _____

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

Your Name: _____

Have you traveled outside the United States in the past year? _____ If yes, where? _____

Dental Information

For the following questions, please mark (x) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets, pressures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping, or discomfort in jaws? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any problems with previous dental treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently experiencing any dental pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of your last dental exam: _____				Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What was done at that time? _____				Date of your last dental x-rays: _____			
How do you feel about your smile? _____				What is the reason for your dental visit today? _____			

Medical Information

Please mark (x) your responses to indicate if you have or have not had any of the following:

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Name: _____				Phone: Include area code _____			
Address/City/State/Zip: _____				Are you taking or have your recently taken any prescriptions or over the counter medicines?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Has there been any changes in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated? _____				_____			
Date of last physical exam: _____				_____			

Medical Information

Please mark (x) your responses to indicate if you have or have not had any of the following.

	Yes	No	DK		Yes	No	DK
Joint Replacement - Have you had an orthopedic total Joint (hip, knee, elbow, finger) replacement?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, any complications? _____				Do you use tobacco? (smoking, vapes, snuff, chew).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies - Are you allergic to or have your had a reaction to: To all yes responses, specify type or reaction				WOMEN ONLY - Are you:			
Local Anesthetic _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of weeks _____			
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking birth control pills or hormonal replacement?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedative or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/seasonal _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Please mark (x) your responses to indicate if you have or have not had any of the following.

	Yes	No	DK		Yes	No	DK	Yes	No	DK	
Have you had heart stents placed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AutoImmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice, or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systematic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____			
If yes, specify: _____				Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other from of CHD.				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	DK	Cancer/chemotherapy/ Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain (exertion)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurring infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infections: _____			
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/ migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	DK	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Has a physician or previous dental recommended that you take antibiotics prior to your dental treatment? _____
 Name of physician or dentist who making recommendation: _____ Phone _____
 Do you have any disease, condition or problem not listed above that you think we 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 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 inquires 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 omission that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

