



## Medical History

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

<input type="checkbox"/> Pre-Med - Amox	<input type="checkbox"/> Pre-Med - Clind	<input type="checkbox"/> Pre-Med - Other	<input type="checkbox"/> Aids/HIV
<input type="checkbox"/> Allergy - Aspirin	<input type="checkbox"/> Allergy - Codeine	<input type="checkbox"/> Allergy - Erythro	<input type="checkbox"/> Allergy - Latex
<input type="checkbox"/> Allergy - Penicillin	<input type="checkbox"/> Allergy - Sulfa	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Heart Valv	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Asthma	<input type="checkbox"/> Back/Neck Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Blood Thinner	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Med Hist/Med List Given	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> MitralValve Prolapse
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Other Heat Problems	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Pregnancy (currently)	<input type="checkbox"/> Prosthesis/Pins/Rods	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease

  

<input type="checkbox"/> Ever been hospitalized (illness or injury)	<input type="checkbox"/> Presently being treated for any other illnesses
<input type="checkbox"/> Subject to frequent headaches	<input type="checkbox"/> Tobacco/Alcohol Use
<input type="checkbox"/> FEMALE: Taking birth control pills	<input type="checkbox"/> FEMALE: Currently Pregnant

If any condition or alerts selected above needs further clarification, please explain below:

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Are you on any blood thinners e.g. aspirin, warfarin, coumadin, heparin..ect.? YES or NO

Any bone or muscle conditions? YES or NO

If yes, please explain: \_\_\_\_\_

Do you take antibiotic premedication for your dental visits? If yes, please explain.

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Any OTHER conditions not mentioned? If so, please explain

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Name of physician and their specialty and phone number (if you do not have one please write "none"):

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Have you had any serious illness or operations?

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List all medications, supplements, and/or vitamins being taken, if none write "none" or "N/A":

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List all allergies, if none write "none" or "N/A":

**By providing a signature, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are NO OTHER medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any and all future changes.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Dental Information

How would you rate the condition of your mouth? Circle one: Excellent      Good      Fair      Poor

Previous Dentist name and phone number: \_\_\_\_\_

I routinely see my dentist every: Circle one: 3 mo.      4 mo.      6 mo.      12 mo.      Not routinely

What is your immediate concern? \_\_\_\_\_

Is there anything about the appearance of your smile that you would like to change?  
\_\_\_\_\_  
\_\_\_\_\_

Personal History, check all that apply:

- Had an unfavorable dental experience
- Had complications from past dental treatment
- Had trouble getting numb
- Had any reactions to local anesthetic
- Had/have braces, orthodontic treatment
- You experience dry mouth
- Any teeth sensitivity to hot, cold, biting, sweets or avoid brushing any part of your mouth
- Food gets trapped between any teeth
- Have you experienced popping and/or clicking of your jaw joint/pain
- You have difficult chewing
- You clench or grind your teeth
- You wear or have worn a bite appliance
- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around your teeth
- Noticed and unpleasant taste or odor in your mouth/bad breath
- Experienced gum recession
- Had any teeth become loose on their own (without injury)
- Have any blisters, sores, or growths
- Have broken fillings
- You bite your fingernails

If any of the checked boxes need further explanation, please describe: \_\_\_\_\_

On a scale of 1-10 how fearful are you of the dentist? \_\_\_\_\_

## **Consent for Services and Financial Policy**

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon payment and/or reimbursement from patients for the costs incurred in their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If your insurance company has not paid your account within 90 days, we will request payment to settle your account. As such you agree as follows: In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any future term or condition and I further agree to pay all costs and reasonable attorney fees if a collection suit be instituted hereunder. I also understand that failure to provide 24 hours' notice when rescheduling or canceling appointments will result in a minimum \$40.00 charge or up to 25% of the scheduled treatment. I further understand that x-rays are property of Mai Dentistry of St. Petersburg and I must give written notice to request them to be duplicated.

By providing a signature, I understand the above information and agree with its contents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **Notice of Privacy Practices Acknowledgment**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: 1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment 2. Obtaining payment from third party payers (e.g. my insurance company); 3. The day to day healthcare operations of your practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

To whom may we release information about your dental treatment/record to? Please state the name and relationship or if there is nobody please indicate that below:

\_\_\_\_\_  
\_\_\_\_\_

Unless otherwise revoked, I understand this authorization expires six (6) years from the date of signature. By providing a signature, I understand the above information and agree with its contents for the HIPAA Disclosure form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Consent for Internet Communications

Our office would like to communicate with you electronically via email and sms. By utilizing our practice's electronic services, you agree that Mai Dentistry of St. Petersburg may communicate with you regarding any information to the email and cell phone number you give us. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warranty that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information and use their best efforts to maintain persons or entities under their direction or control to comply with such laws. I understand the dental practice will use commercially reasonable efforts to maintain confidentiality of all patient information that is used with any electronic services. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THESE SERVICE.

**I have read the information above and grant the dental practice permission to contact me electronically.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Photo Release

I hereby authorize Mai Dentistry of St. Petersburg permission to use my likeness in any and all of its publications. I understand and agree that any photographs using my likeness will become property of Mai Dentistry of St. Petersburg. I acknowledge that since my participation with Mai Dentistry of St. Petersburg is voluntary, I will receive no financial compensation. I hereby authorize Mai Dentistry of St. Petersburg to edit, alter, exhibit, publish, or distribute this or these photo(s). In addition, I waive my right to inspect or approve the finished photo, including written or electronic copy. Additionally, I waive the right to any royalties, or any other compensation arising or related to the use of the photo(s).

**I am at least 18 years of age and competent to consent in my own name. I have read this release before signing and fully understand the contents, meaning, and impact of this release.**

Signature \_\_\_\_\_ Date \_\_\_\_\_