

Medical History

Do you have a personal physician? Yes No

Physician's Name and Phone #: _____

Have you had any joints replaced? Yes No

If so, where and when? _____

Are you taking any medications (including aspirin)? Yes No

Please list each one: _____

Do you use tobacco in any form? Yes No

If yes, what kind and how much: _____

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemotherapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Facial Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis A, B, C</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint Replacement</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Pace Maker</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p>	<p>Yes No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine</p> <p><input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics</p> <p><input type="checkbox"/> <input type="checkbox"/> Erythromycin</p> <p><input type="checkbox"/> <input type="checkbox"/> Jewelry</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex</p> <p><input type="checkbox"/> <input type="checkbox"/> Metals</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> <input type="checkbox"/> Tetracycline</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>
			<p>Yes No If Female, Please Answer</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If so, # of Weeks _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you nursing?</p>



455 Cascade Loop
Kalispell, MT 59901
Ph- 406-752-6684
Fax- 406-309-2770
toothbootmt@gmail.com

Dental History

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

How many times a day do you: brush? _____ floss? _____

When was your last dental visit? _____ dental cleaning? _____

Who is your prior dentist/Why did you leave? _____

How can we accommodate you better during your dental visit? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** _____

Please know, we value each and every one of our patients. To provide the best possible care to all of you, we appreciate a 48-hour notice for appointment changes or cancellations. Without providing this notice, it is possible to lose your patient status at our office.

Sign

Date



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*You may refuse to sign this acknowledgment

I, _____, have received a copy of this office’s Notice of Privacy practices.

Print name and phone numbers of anyone allowed information- ER CONTACT, Adults who may bring children, Spouse’s who may make appointments, etc.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)