



Confidential Health History Information

Patient Name: _____ Initial Date: _____

Updated: _____

Updated: _____

Personal Health Information

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Please answer the following questions to the best of your ability:

<p>Have you been hospitalized within the past 2 years? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for what? _____ _____</p> <p>Are you currently being treated by a physician? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for what? _____</p> <p>Are you currently taking and medicines or drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> What? _____</p> <p>Have you ever received counseling for excessive use of alcohol and/or prescription drugs? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you allergic to any drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what? _____</p> <p>Have you ever had a skin rash or other reaction to metal jewelry? Yes <input type="checkbox"/> No <input type="checkbox"/> What? _____</p> <p>Do you bleed excessively upon injury? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you ever been involved with dental/medical legal activity? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Please Check Any of the Following Conditions That You Have Had in the Past or Now Have:</p> <table border="0"> <tr> <td><input type="checkbox"/> AIDS</td> <td><input type="checkbox"/> Kidney Problems</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Low Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Nervous Breakdown Or Psychiatric Therapy</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Osteoporosis</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Sexually Transmitted Diseases</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Heart Murmur</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Heart Problem</td> <td><input type="checkbox"/> Anemia</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Latex Allergy</td> </tr> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Surgical Implants</td> </tr> <tr> <td><input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis ABC (circle one)</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Herpes</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Artificial Joints</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Chemotherapy/Radiation</td> <td></td> </tr> </table>	<input type="checkbox"/> AIDS	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Nervous Breakdown Or Psychiatric Therapy	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Surgical Implants	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other	<input type="checkbox"/> Hepatitis ABC (circle one)	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Artificial Joints		<input type="checkbox"/> Chemotherapy/Radiation	
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Person to Be Contacted in Case of Emergency

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____



Confidential Patient Information

Date: _____

PERSONAL INFORMATION

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ E-mail: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Name: _____ SS #: _____

Relationship to Patient: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____ Policy #: _____

Group #: _____ Subscriber Name: _____

SS #: _____ Relationship: _____ Birth date: _____

Secondary Insurance Co: _____ Policy #: _____

Group #: _____ Subscriber Name: _____

SS #: _____ Relationship: _____ Birth date: _____

I understand that payment is my obligation regardless of insurance or any other third-party agreement.

Patient/Guardian Signature

Date

Troutdale Dental

191 E Historic Columbia River Hwy, Troutdale, OR 97062 – (503) 674-8767

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*** You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}

{Relationship}

{Please Print Name}

{Relationship}

{Please Print Name}

{Relationship}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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)



Smile Evaluation (Optional)

Do you like your smile? Yes No

If no, and you could change anything about your smile, what would you change?

Are you happy with the color of your teeth? Yes No

Would you like your teeth to be whiter? Yes No

Would you like your teeth to be straighter? Yes No

Do you have spaces between your teeth that you would like closed? Yes No

Would you like your teeth to be longer? Yes No

Do you like the shape of your teeth? Yes No

Explain: _____

Do you have missing teeth that you would like replaced? Yes No

Explain: _____

Do you have old silver fillings that you would like replaced with tooth-colored fillings?
Yes No

Would there be any reason not to go ahead with any needed dental treatment? Yes No

Explain: _____

What makes you most comfortable in a dental practice? What can we do to achieve this?

Explain: _____

What makes you least comfortable in a dental practice?

Explain: _____

