SIU COMMUNITY DENTAL CENTER
HEALTH HISTORY

Date:			
Name:		DOB:	Phone:
Address:		Zip:	Occupation:
City:	Height:	Weight:	Sex: M F
Email:			
Emergency Contact:		Relationship:	Phone:
If you are completing this form for another person, what is your relationship to that person:			
Your Name:		Relationship:	
How did you hear about us?			

DENTAL HISTORY

Do your gums bleed when you brush or floss?	yes no
Are your teeth sensitive to cold, hot, sweets, or pressure?	yes no
Is your mouth dry?	yes no
Have you ever had periodontal (gum) treatments?	yes no
Do you wear partials or dentures?	yes no
Are you currently experiencing dental pain or discomfort?	yes no
Date of last dental exam?	
What is the reason for your dental visit today?	

MEDICAL INFORMATION

Are you now under the care of a physician? yes no	Date of last physical exam?
Physician Name:	Have you had a serious illness, operation, or been hospitalized in the last 5 years? yes no
Physician Phone:	If yes, what was the illness or problem?
Address/City/State/Zip:	**List all current medications:**
Has there been any change in your general health within the last year? yes no	
If yes, what condition is being treated?	

SIU COMMUNITY DENTAL CENTER
HEALTH HISTORY

Please indicate if you have or have not had any of the following:

Total Joint Replacement If yes, when:	yes no	Mitral valve prolapse	yes no	Artificial heart valve If yes, when:	yes no	Kidney problems	yes no
Do you use tobacco?	yes no	Angina	yes no	Rheumatoid arthritis	yes no	Abnormal Bleeding	yes no
Are you pregnant?	yes no	Arteriosclerosis	yes no	osteoporosis	yes no	Blood transfusion	yes no
Stroke If yes, when:	yes no	Congestive heart Failure	yes no	Systemic Lupus erythematosus	yes no	Hepatitis, Jaundice, Liver Disease	yes no
Previous infective endocarditis	yes no	Heart murmur	yes no	Mental health disorder	yes no	AIDS/HIV	yes no
Cardiovascular disease	yes no	High/Low blood pressure	yes no	Autoimmune Disease	yes no	Hemophilia	yes no
Arthritis	yes no	Do you snore	yes no	Cancer/Chemotherapy/ Radiation	yes no	Chronic Pain	yes no
Pacemaker	yes no	Sleep Apnea	yes no	Tuberculosis	yes no	Neurological disorders	yes no
Rheumatic heart disease	yes no	Asthma	yes no	Epilepsy	yes no	Anemia	yes no
Heart attack If yes, when:	yes no	Bronchitis	yes no	Diabetes Type I/Type II	yes no	GERD	yes no
Congenital heart disease	yes no	Emphysema	yes no	Gastrointestinal Disease	yes no	Thyroid problems	yes no
Are you taking or scheduled to begin taking medications for osteoporosis (Fosamax, Actonel, Atelvia, Bonia, Reclast, Prolia)?		yes no		Any other disease or condition please list:			

ALLERGIES

Local Anesthetics	yes no	Aspirin	yes no	Seasonal	yes no
Penicillin or other antibiotics	yes no	Metals	yes no	Animals	yes no
Sulfa Drugs	yes no	Iodine	yes no	Food	yes no
Codeine or other narcotics	yes no	Silver	yes no	Latex	yes no
Other:					

I certify that the above information given on this form is accurate. I understand the importance of a truthful heath history and that my dentist and staff will rely on this information for treating me.

Signature of patient/ Legal Guardian _____

SIU Southern Illinois University
CARBONDALE

COMMUNITY DENTAL CENTER
1365 Douglas Drive
Carbondale, IL 62901
(618)453-2353

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

My signature on this form acknowledges receipt of the SIUC Community Dental Center **NOTICE OF PRIVACY PRACTICES** indicating how my medical information shall be used and disclosed, and how I can gain access to this information.

Patient Name (printed):_____ Date:_____

Parent/Guardian:_____

Signature:_____

NO SHOW POLICY

STATEMENT OF UNDERSTANDING REGARDING "NO SHOW" APPOINTMENT POLICY

A "No show" is when a patient does not show up or does not call to cancel PRIOR to the time of a scheduled appointment.

All No shows will be documented in the patient's chart. If a 2nd "NO SHOW" should occur, the patient may be formally dismissed from the office.

When a patient is dismissed from the practice, the office will provide ONLY emergency care for a period of 30 days.

As a courtesy to others, we reserve the right to reschedule your appointment if you are more than 15 minutes late.

I have read and understood this policy

Circle One: Patient Parent Guardian

Patient Name (Print):_____ Date:_____

Parent/Guardian:_____

Signature:_____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize SIU Community Dental Center to release my records and any information requested to the following individuals:

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

4. _____ Relation to Patient:_____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature