



Gary Roth DDS - Alex Roth DDS - Melanie Norton DDS
205 North B Street Fairfield, IA 52556 (641)472-3044
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WELCOME

Thank you for choosing our dental health care team! Please provide us with a thorough history of past and current medical treatments; to include all medications (prescription and over the counter), all known drug allergies/adverse reactions, recent and past surgeries and hospitalizations.

While it may not seem of any consequence, many medical conditions and medications can have a significant impact on dental treatment and diagnosis. In order for us to best serve you in the safest environment possible please be as complete as you can and do not hesitate to ask us if any assistance is needed – we will be happy to help!

All information in this form is confidential and only for our records.

Thank You!
Roth & Norton Family Dentistry

PATIENT INFORMATION

Patient Name _____ Preferred Name _____

Birth Date _____ Social Security Number(SSN) _____

If a Minor, parent or legal guardian's name _____ SSN _____

Home Phone _____ Work Phone _____ Cell Phone _____

Mailing Address _____ City _____ State _____ Zip _____

Email Address _____

Occupation _____ Employer _____

If Married: Spouses Name _____ Employer _____

How did you hear about our office/who can we thank for referring you? _____

What is the primary reason you are seeking dental care today? _____

EMERGENCY CONTACT: NAME _____ PHONE # _____

PATIENT MEDICAL HISTORY

1. Current Medical Treatment Facility _____
2. Current Physician or other Health Care Provider _____
3. Date of Last Exam/Physical _____
4. Are you currently under medical treatment now? Y N
If yes please explain: _____
5. Have you been hospitalized within the last 5 years for any surgical operation or serious illness? Y N
If yes please explain: _____
6. Are you currently taking any medications (i.e prescription, over the counter and/or herbals)? Y N
Please list: _____
7. Have you ever taken Fosamax, Boniva, Actonel or other Bisphosphonates to treat cancer? Y N
If yes, when were these were taken? _____
8. Do you currently use tobacco products? Y N Were you a past of user of tobacco? Y N
If a smoker, how much for how long? _____
If a user of smokeless tobacco how much for how long? _____
9. Do you have any clotting or bleeding disorders, or taking any anti-clotting medication to include Aspirin? Y N
If yes please explain: _____
10. Do you have any artificial joints or heart valves? Y N
If yes please explain and if possible include date of surgery: _____
11. Are you allergic or had any adverse reactions to any of the following?
Local Anesthetics (i.e Novocain): Y N
Latex Materials: Y N
Antibiotics: Y N Which one(s) _____
Codeine or other Narcotic Pain Medications: Y N
NSAIDS (i.e Ibuprofen (Motrin), Tylenol, Aspirin): Y N
Any metals (i.e nickel, tin, gold etc.)
Please list any other allergies you may have: _____

12. Have you ever had or have any of the following? (Please 'X' or Circle condition)

High Blood Pressure	Heart Disease	Seasonal Allergies
Heart Attack	Heart Murmur	Tuberculosis
Stroke	Angina	Other lung/respiratory illness
Rheumatic Fever	Frequently Tired	Glaucoma
Seizure Disorder	Sleep Apnea	Other eye illness
Fainting Spells	Blood Disorder	History of Alcohol Abuse
Asthma	Emphysema	Cardiac Pacemaker
Low Blood Pressure	Cancer	Bronchitis/Chronic Cough
Leukemia	Arthritis	Mental Health Problems
Diabetes	Hepatitis/Jaundice	Radiation to the head or neck
Kidney Disease	STD's/STI's	Osteoporosis
AIDS/HIV Infection	Stomach Ulcers	Immune System Disorder
Thyroid Condition	Acid Reflux/GERD	OTHER: _____

13. For Women: Are You Pregnant or think it is a possibility you could be Pregnant? Y N Delivery Date _____
Are You Nursing? Y N
Are You Taking Oral Contraceptives? Y N

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Visit _____

Do you experience anxiety or fear prior to and/or during dental treatment? Y N

Do you have a history of "bad" experiences at the dentist? Y N

Do you have a significant gag reflex or gag easily? Y N

Have you ever experienced any prolonged bleeding after dental treatment? Y N

Do you currently have any pain associated with any of your teeth? Y N

Do your gums bleed frequently when you brush and/or floss? Y N

Do you have any sores or lumps in your mouth that come and go or do not heal? Y N

Do you have a history of trauma or injuries to the face, jaws, teeth or head? Y N

Do you suffer from frequent Sinus issues/infections? Y N

Do you suffer from xerostomia (dry mouth)? Y N

Have you ever had orthodontic treatment (braces on your teeth)? Y N

Do you suffer from any of the following Temporomandibular Joint (TMJ) issues?

Clicking or popping on one or both sides? Y N

Pain in the joint/ear/face? Y N

Limited or difficult opening/closing of the mouth? Y N

Pain when chewing? Y N

Is there a specific time of day the pain is at its worst? _____

Have you been told or know if you clench or grind your teeth at night or during the day? Y N

Do you have sensitive teeth? Y N

If yes what triggers the sensitivity: _____

Do you like your smile? Y N

If NO, what would you change about it?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I also understand that any voluntary omissions of vital medical history cannot be the responsibility of the dental surgeon or any member of the Roth & Norton Dental staff and I certify that all questions above have been answered to the best of my ability.

Signature of patient/legal guardian

Date MM/DD/YYYY



Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and that I may request a copy at any time.

Patient Name _____ Date of Birth _____

Signature of patient or legal guardian: _____

Date: _____

If not signed by the patient, please indicate the relationship to patient:

- Parent of minor patient
- Guardian
- Power of attorney

Name: _____

Authorization for Release of Information

If you wish to have your medical or billing information released to family members, please complete the section below. Completing this section will only give information to family members indicated below.

I authorize Roth Dental Care to release my medical and/or billing information to the following individual(s):

1 _____ Relationship to Patient: _____

2 _____ Relationship to Patient: _____

3 _____ Relationship to Patient: _____

This Release of Information will remain in effect until terminated in writing by the patient.



DENTAL APPOINTMENT POLICY

A missed dental appointment presents problems for us both. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health.

For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality and personal care that every patient deserves.

We do not feel right about charging for a missed appointment. We simply ask you to be very faithful about keeping all future dental appointments.

We understand that unplanned issues can come up and you may need to change an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled or rescheduled at least 24 hours in advance. Roth & Norton Family Dentistry offices reserve the right to not reschedule appointments or dismiss patients due to broken appointments.

Thank you for your understanding and cooperation of this policy. We value you as a patient and look forward to seeing you for future appointments.

In good health,

Roth & Norton Family Dentistry

Signature of patient/legal guardian

Date MM/DD/YYYY