Roth & Norton
FAMILY DENTISTRY

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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 _____

Dental insurance company_____ Policy ID #_____

Occupation_____ Employer_____

If Married: Spouses Name_____ Employer_____

What is your primary concern 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. Current Pharmacy/Pharmacy Preference: _____
5. Are you currently under medical treatment now? Y N
   If yes please explain:_____
   _____
6. Have you been hospitalized within the last 5 years for any surgical operation or serious illness? Y N
   If yes please explain:_____
   _____
7. Are you currently taking any medications (i.e prescription, over the counter and/or herbals)? Y N
   Please list:_____
   _____
8. Have you ever taken Fosamax, Boniva, Actonel or other Bisphosphonates to treat cancer? Y N
   If yes, when were these were taken?_____
9. 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?_____
10. Do you have any clotting or bleeding disorders, or taking any anti-clotting medication to include Aspirin? Y N
    If yes please explain:_____
11. Do you have any artificial joints or heart valves? Y N
    If yes please explain and if possible include date of surgery:_____
12. 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:_____
    _____
13. Have you ever had or have any of the following? (Please 'X' or Circle condition)

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

14. 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: _____

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

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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.

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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