

Ned S. Jennings, DMD, Inc.

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(803)254-9045

Medical & Dental History Form

Patient Name: _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? Yes No

Within the past year, have there been any changes in your general health? Yes No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Are you currently taking any prescription or non-prescription medications?
- Are you taking or have you ever taken any medications or injections for Osteoporosis.
- Do you use tobacco (smoking or chewing)?
- Do you require the use of corrective lenses (contacts or glasses)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant? Yes No

Please indicate if you have experienced any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Autistic | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lodine |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> MitralValve Prolapse | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No Anesthetic |
| <input type="checkbox"/> No Epinephrine | <input type="checkbox"/> No Proply Jet | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> PREMEDICATE | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

- 3 (+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

- 1 (+) a day 2 - 6 weekly 1 - 6 monthly Seldom Never

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
- Do your teeth experience sensitivity to cold or hot temperatures?
- Are any of your teeth currently causing you pain?
- Do you grind your teeth (either consciously or during sleep)?
- Are any of your teeth loose, or are you concerned about any teeth loosening?
- Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all costs of collection, including filing fees and attorney fees. There will be a \$40.00 charge on all returned checks. If the bank charges us a fee you will also be responsible for that charge.

There will be a \$35.00 charge for any appointments cancelled or broken with a notice of less than 36 hours. After 3 offenses, appointments may be subject to a deposit prior to services rendered and will not be refunded if appointment is missed.

Signature of patient, parent, or guardian:

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT PRIVACY NOTICE

Note: The HIPPA Privacy regulation requires us to make good faith effort to obtain patient's written acknowledgement of receipt of the Notice of Privacy Practice. I acknowledge that I have received a copy of Dr. Ned Jennings' Notice of Privacy Practice with the effective date of April 14, 2003.

(A complete copy of the Privacy Notice are available upon request)

I understand that I am ultimately responsible for all cost of my dental treatment. I authorize Ned S. Jennings DMD and staff to perform necessary treatment to maintain proper dental care. I have read the above condition of treatment and Acknowledgement of HIPPA Privacy and agree to their content.

(Copies of HIPPA Privacy available upon request)

Signature _____ Date _____

Response Date: ____/____/____