HEALTH HISTORY

VALLEYHEALTH

Quality healthcare in your neighborhood.

Name:_____

Reason for today's visit_____ Previous Dentist and Date_____

DO YOU HAVE OR EVER HAD THE FOLLOWING (PLEASE CIRCLE YES or NO FOR EACH QUESTION)

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? YES NO

IF SO, WHAT IS THE CONDITION BEING TREATED?_____
NAME AND ADDRESS OF MY PHYSICIAN_____

HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR BEEN HOSPITALIZED IN THE LAST 5 YEARS? YES NO
IF SO, WHAT WAS THE ILLNESS/PROBLEM_____

HAVE YOU RECEIVED THE COVID-19 VACCINE? YES NO

HEART MURMUR	YES	NO	CONGENITAL HEART LESIONS	YES	NO
RHEUMATIC FEVER	YES	NO	MITRAL VALVE PROLAPSE	YES	NO
ARTIFICIAL HEART VALVES	YES	NO	SCARLET FEVER	YES	NO
CARDIAC PACEMAKER	YES	NO	HIGH BLOOD PRESSURE	YES	NO
DIABETES	YES	NO	STROKE	YES	NO
HEPATITIS A, B, C	YES	NO	AIDS/HIV	YES	NO
TUBERCULOSIS	YES	NO	SINUS PROBLEMS	YES	NO
ASTHMA	YES	NO	ANEMIA	YES	NO
HEMOPHILIA/BLEEDING DISORDER	YES	NO	EPILEPSY/ OR NEUROLOGICAL DISEASE	YES	NO
FAINTING SPELLS OR SEIZURES	YES	NO	HERPES	YES	NO
KIDNEY TROUBLE	YES	NO	LOW BLOOD SUGAR	YES	NO
PERSISTANT SWOLLEN NECK GLANDS	YES	NO	PROBLEMS WITH MENTAL HEALTH	YES	NO
PROBLEMS WITH IMMUNE SYSTEM	YES	NO	SEXUALLY TRANSMITTED DISEASE	YES	NO
STOMACH ULCER OR HYPERACIDITY	YES	NO	THYROID PROBLEMS (HYPER? Or HYPO?)	YES	NO

RESPIRATORY PROBLEMS, EMPHYSEMA, BRONCHITIS ETC. YES NO

HEART ATTACK	YES	NO	IF YES, WHEN_____
OTHER HEART PROBLEMS	YES	NO	EXPLAIN_____
HEART STENTS	YES	NO	IF YES, WHEN_____
BACTERIAL ENDOCARDIDITS	YES	NO	
PROSTHETIC JOINT REPLACEMENT	YES	NO	IF YES, WHAT JOINT AND WHEN_____
CANCER	YES	NO	IF YES, WHEN AND WHAT TYPE_____

DO YOU HAVE A CONDITION, ILLNESS OR OTHER MEDICAL CONDITION NOT DISCUSSED ABOVE? YES NO

IF YES, PLEASE LIST CONDITION(S):_____

DO YOU SUFFER FROM CLICKING OR POPPING IN YOUR JAW? YES NO EXPLAIN_____

HAVE YOU EVER HAD TO HAVE ANTIBIOTIC PREMED IN THE PAST FOR JOINT REPLACEMENT OR HEART CONDITIONS? YES NO

DO YOU SMOKE CIGARETTES (INCLUDING E-CIGARETTES) ON A DAILY BASIS? YES NO

IF YES, HOW MUCH IN A DAY?_____

DO YOU USE SMOKELESS TOBACCO ("SNUFF" OR "CHEW") ON A DAILY BASIS? YES NO

IF YES, HOW MUCH IN A DAY?_____

DO YOU CONSUME ALCOHOL ON A DAILY BASIS? YES NO

IF YES, HOW MUCH IN A DAY?_____

DO YOU CURRENTLY USE OR HAVE USED IN THE PAST COCAINE, MARIJUANA, METHAMPHETAMINE, HEROIN, OR OPIOIDS FOR RECREATIONAL PURPOSES IN THE PAST 12 MONTHS? YES NO

ARE YOU CURRENTLY BEING TREATED OR HAVE BEEN TREATED IN THE PAST FOR DRUG ADDICTION? YES NO

ARE YOU CURRENTLY TAKING (OR HAVE IN THE PAST) SUBOXONE, SUBUTEX, VIVITROL, SUBLOCADE OR METHADONE? YES NO

DO YOU CONSUME SUGARY DRINKS (e.g."SODA", "POP", "SPORTS DRINKS"," JUICE")? YES NO

IF YES, HOW MUCH AND HOW OFTEN ON A DAILY BASIS?_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: PLEASE CIRCLE ALL THAT APPLY

CODEINE SULFA PENICILLIN LATEX LOCAL ANESTHETIC OTHER_____

ARE YOU OR COULD YOU CURRENTLY BE PREGNANT? YES NO IF YES, WHEN IS YOUR DUE DATE_____

ARE YOU CURRENTLY BREASTFEEDING? YES NO

PLEASE LIST <u>ALL MEDICATIONS</u>, INCLUDING OVER THE COUNTER MEDICINES. IT IS VERY IMPORTANT WE KNOW ALL MEDICATIONS AS THEY CAN INTERFERE WITH DENTAL ANESTHETICS (NUMBING MEDICATION).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PATIENT SIGNATURE (GUARDIAN) DATE

REVIEWED BY:_____ DATE:_____

Patient Info Label Here

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Dental Treatment Consent Form

Please Read And Initial The Items Checked Below. Also, Read And Sign The Section At The Bottom.

√ ***AUTHORIZATION FOR DENTAL TREATMENT***- I hereby authorize and direct dentist and dental professional staff of Valley Health to provide dental treatment to the above named patient. I agree to examination, evaluation, treatment, diagnostic tests, procedures, and administration / injection of pharmaceuticals. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination**.**

Initials_____

Non-Covered Services Financial Agreement

I understand that regardless of my insurance status, I am responsible for any service, including x-rays, which are not covered by my insurance or the sliding fee program. I also understand that I am responsible for any co-pays, deductibles or percentages that my insurance/sliding fee does not cover.

A panorex x-ray provides a full view of the entire oral cavity. The panorex is one x-ray that provides a picture of all your teeth and the surrounding bones; it can detect potential problems other x-rays cannot. A panorex is an excellent way for your dentist to check for problems such as: cysts or tumors, gum disease, tooth and jaw development and impacted wisdom teeth. This x-ray may not be covered by your insurance, if you have other x-rays taken the same day. Please inform your dentist and or staff member if you refuse this x-ray.

It is my responsibility to understand my insurance coverage, but as a courtesy, the staff of Valley Health will make every effort to inform me of non-covered procedures before they are performed.

I also understand that Valley Health will not attempt to submit a claim to my insurance for any non-covered service that I choose to receive, and that I am financially responsible for the entire cost of that service. I also agree to pay for these services and/or any co-pays or deductibles, in full, at the time of the visit.

Patient(Parent/Guardian)_____Date_____

Witness_____Date_____

Patient Info Label Here

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Dental Treatment Consent Form: *Please Read And Initial*
The Items Checked Below. Also, Read And Sign The Section At The Bottom.

✓ **LOCAL ANESTHESIA:** Lidocaine, Septocaine, and other similar agents are injected in the mouth to block pain pathways in a local area. The administration of theses agents or any medication involves certain risks which include: pain, swelling, inflammation, infection, or injury to nerves or blood vessels in the area of the injection, numbness (partial or complete) that may or may not be permanent. In rare instances, nausea and vomiting or an allergic or unexpected reaction may occur which may require treatment. If you have any questions, please ask.

Initials_____

✓ **FILLINGS:** To avoid breakage, I understand that care must be taken when chewing on fillings, especially during the first 24 hours. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.

Initials_____

✓ ***CROWNS, BRIDGES, AND CAPS***- I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

Initials_____

✓ ***PERIDONTAL LOSS (TISSUE & BONE***) - I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials_____

I understand the dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and I consent to the proposed treatment.

Patient (Parent/Guardian)_____Date_____

Witness_____ Date_____