PARK DENTISTRY LLC

MEDICAL HISTORY

What is your estimate of your general health?
Date of most recent physical examination:
Purpose:

Physician name:
Physician specialty:

Do you have or have you ever had the following:

1 . Hospitalization for illness or surgery: Yes (explain) _____ No

2 . Please circle all that apply if you are Allergic or bad reaction to any of the following: aspirin ibuprofen acetaminophen codeine penicillin erythromycin tetracycline sulfa local anesthetic fluoride chlorhexidine latex nickel gold silver titanium nuts fruit milk red dye other _____

3 . Heart problems or cardiac stent within the last six months:
Yes - within the last 6 months / Yes – over 6 months with no symptoms / Yes – over 6 months with symptoms (angina, shortness of breath) / No

4 . History of infective endocarditis: Yes (when) _____ No

5 . Artificial heart valve / repaired heart defect (PFO): Yes (when)_____ No

6 . Pacemaker / implantable defibrillator: Yes (when) _____ No

7 . Orthopedic or soft tissue implant (joint replacement, breast implant):
Yes (when) _____ No Do you take a premedication: Yes or No

8 . Please circle all that apply : Heart murmur, rheumatic fever, scarlet fever: Yes No

9 . Please circle all that apply: High or Low blood pressure: Yes No

10 . Stroke Yes or No Please circle all that apply: within the last 6 months over 6 months
Do you take blood thinners? Yes or No

11 . Please circle all that apply: Anemia Other blood disorder Low blood pressure Yes No

12 . Prolonged bleeding due to a slight cut (INR > 3.5) Yes or No Past condition or Ongoing

13 . Please circle all that apply: Pneumonia, emphysema, shortness of breath while sitting without activity, sarcoidosis: Yes No

14 . Chronic Ear Infections, tuberculosis, measles, chicken pox: Circle which one if Yes No

15 . Breathing Problems (circle any that apply) Asthma with occasional use of inhaler, Asthma with frequent attacks, nasal breathing, stuffy nose, sinus congestion

16 . Sleep problems (circle any that apply) Sleep Apnea, Snoring, Insomnia, restless sleep, bedwetting

17 . Kidney disease or kidney stone (circle any that apply)

18 . Liver disease or Jaundice (circle any that apply)

19 . Vertigo or Dizziness (circle any that apply)

20 . Thyroid, parathyroid disease, Calcium Deficiency (circle any that apply)

21 . Hormone deficiency or imbalance (poly cystic ovarian syndrome) (circle any that apply)

22 . High Cholesterol: Yes or No (If yes are you taking a Statin Drug) Yes No

23 . Diabetes: (Circle all that apply) Type I or Type II
HbA1c / Average Blood Sugar
Less than 7%
Less than 140 mg/dL - 7.8 mmol/L 7-9%
Between 140 to 200 mg/dL – 7.8 to 11.1 mmol/L
More than 9%
More than 220 mg/dL – 12.2 mmol/L

24 . Stomach Ulcer or Duodenal Ulcer (circle any that apply)

25 . Digestive or eating disorders (circle any that apply) Celiac disease, gastric reflux, bulimia, anorexia, irritable bowel syndrome, inflammatory bowel disease, Crohn's, other digestive disorders

26 . Osteoporosis / Osteopenia (circle any that apply) Taking Bisphosphonates or anti resorptive medicines

27 . Arthritis or Gout (circle any that apply)

28 . Autoimmune disease (circle any that apply) Rheumatoid arthritis, lupus, scleroderma, other

29 . Glaucoma Yes or No

30 . Contact lenses Yes or No

31 . Head injures or Neck Injuries (circle any that apply)

32 . Epilepsy, Convulsions, Seizures (circle any that apply) Are these controlled or uncontrolled

33 . Please circle all that apply: Neurologic disorders: (circle any that apply) Alzheimer's disease, Dementia, Prion disease

34 . Viral infections, Cold sores, bacterial infections, Lyme disease (circle any that apply)

35 . Lumps in mouth or swelling in mouth Yes or No

36 . Hives, skin rash, hay fever, other skin disease (circle any that apply)

37 . STI, STD, HPV (circle any that apply)

38 . Hepatitis: Yes or No (circle any that apply) Type A Type B Type C

39 . HIV or AIDs (circle any that apply)

40 . Tumor or Abnormal growth (circle any that apply)

41 . Radiation therapy Yes or No If Yes date last completed:_____

42 . Chemotherapy Yes or No If yes date last completed: _____

43 . Difficulties with stress management Yes or No

44 . Psychiatric treatment Yes or No
If yes are you taking antidepressant medication Yes or No

45 . Concentration problems Yes or No ADD or ADHD diagnosis Yes or No

46 . More than 14 units of alcohol use or Recreational drug use (circle any that apply)

47 . Are you being treated for any other illness? Yes _____ No

48 . Are you aware of change in your health in the last 24 hours (fever, chills, new cough, diarrhea) Yes or No

49 . Are you taking medication for weight management? Yes or No

50 . Are you taking any of the following: (circle any that apply) Supplements, Probiotics, Vitamins

51 . Are you often exhausted or fatigued: Yes or No

52 . Are you experiencing frequent headaches or chronic pain: Yes or No

53 . Are you a smoker, used to smoke, smokeless tobacco, vaping, e-cigarettes, cannabis (circle any that apply)

54 . Are you considered a touchy or sensitive person Yes or No

55 . Are you often unhappy or depressed Yes or No

56 . FEMALES Are you taking birth control pills Yes or No

57 . FEMALES Are you pregnant Yes or No (1^{st} 2^{nd} 3^{rd} trimester)

58 . MALES Are you diagnosed with a prostate disorder Yes or No

59 . Are you having other genital or urinary system disorders Yes or No

60 . Are you having any surgeries in the future Yes or No

61 . Do you have or had any flu like symptoms in the past 14 days (circle any that apply)

62 . Are you awaiting results for COVID 19 lab test Yes or No

63 . Have you tested positive for COVID in the past 14 days Yes or No

64 . Are you or a family member previously asked to self-isolate or self-quarantine in the past 14 days Yes or No

65 . Have you had close contact to an individual diagnosed with COVID 19 in the past 14 days Yes or No

66 . Have you traveled in the past 14 days to a region with high rates of COVID 19 activity Yes or No

List your Medications you are currently taking :

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Authorization to Disclose Health Information to Family Members, Friends, and Caregivers

Patient Name: **Date of Birth: / /**

Many of our patients allow spouses, parents, caregivers, and/or others to call and request medica, billing, appointment, and personal information. Under the requirements of HIPPA we are not allowed to give this information to anyone without our patients' consent. If you wish to have your medical, billing, and/or personal information released to family members, friends, caregivers, and/or healthcare providers you must list your preferences below and sign this form.

I hereby authorize Park Dentistry to release my patient information as described below:

Patient's Chosen Representative/Representative's Relationship to Patient		Type of Information Allowed to Disclose (Check all that apply)			Method of Disclosure (Check one or both)	
Name/Phone Number	Relationship	Dental/ Medical	Account /Billing	Personal	By Phone	In Person

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments, and test results. Account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claim status, and third-party financing. Personal information including, but not limited to, the patient's general health and well-being.

I understand that the Health Insurance Portability and Accountability Act of 1196 and its implementing regulations ("HIPAA") govern the terms of this authorization. I understand that I have the right to revoke to authorization at any time prior to the practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions the right to revoke and a description of how I may revoke his authorization is set forth in DDA's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

I understand that I am not required to sign this authorization and that DDA may not condition treatment on my execution of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, , have reviewed a copy of this office's Notice of Privacy Practices.

Signature: **Date:**

Parent of:

Guardian/POA for:

Copy of Privacy Practice Notice Available Upon Request

(Check One) I DO DO NOT GIVE PERMISSION to Park Dentistry to leave information on my answering machine and/or with my family members, care giver, and/or friend regarding treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of our practice. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, we will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

Signature of Patient or Personal Representative (i.e. Guardian) Date

Relationship of Personal Representative to Patient