ADA American Dental Association®

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. **Yes No ?**

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐
If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).
If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements**? ☐ ☐ ☐
If yes, please list them here and include information about how much and how often you use each one. _____

Do you use **GLP-1 Glucagon-Like Peptide-1 medication**? ☐ ☐ ☐

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐

Nursing? If yes, number of weeks: _____ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5˚F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐
Over the past two weeks, have you felt connected to the world around you?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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COMMUNITY DENTAL CLINIC

PATIENT INTAKE FORM

Last Name: _____ **First Name:** _____ MI: ____

Preferred: _____ **Gender:** M / F / Other **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Emergency Contact: _____ Relationship: _____

Phone: _____ **Email:** _____

Primary Care Physician: _____ Phone: _____

Pharmacy:_____ Address: _____

Are you a Veteran? (Y / N) If yes, are you registered with the VA for services? (Y / N)

How did you hear about us?

☐ ER ☐ Urgent Care ☐ Health Deptartment ☐ Family/Friend

☐ Clearwater Free Clinic ☐ Homeless Empowerment Program (HEP) ☐ Arc of Tampa Bay

☐ VA ☐ Salvation Army ☐ Hope Villages ☐ Gulf Coast Dental Outreach

☐ Internet/Web Search ☐ WVFR ☐ 211 ☐ Find Help Florida

☐ Other: _____

What transportation do you use to get to and from your appointments?

☐ Self ☐ Friend/Family ☐ Ride Share Service (Uber/Lyft)

☐ Bus ☐ Medical Transport ☐ _____

If our services were not available, where would you have gone for treatment?

☐ ER/Urgent Care ☐ Private Dental Practice ☐ Nothing ☐ I'm Not sure

☐ Other: _____

I certify that the above information is true. I am aware that I will be refused treatment if any of the information I provide to the CDC is false or if I withhold information. I give permission for the above information to be verified. I understand I will be responsible for any costs associated with my dental care that are provided outside the CDC, such as emergency room visits or referrals to specialists not available at the clinic.

Patient Signature: _____ Date: _____

COMMUNITY DENTAL CLINIC

HIPAA COMPLIANCE

Last Name: _____ First Name: _____ MI: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Community Dental Clinic we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information (**PHI**) and to give you this notice explaining our privacy practices regarding that information. This notice explains your rights and our legal obligations regarding the privacy of your **PHI**.

Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information.

For your Treatment: Your **PHI** may be provided to a physician or healthcare provider to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide you with a service.

For Health Care Operations: We may use and disclose your **PHI** to support the business activities of your physician's or healthcare provider's office. These activities include, but are not limited to, the evaluation of our team members in caring for you and quality assessment.

Appointment Reminders/Treatment Alternatives/ Health-Related and Services: We may use and disclose your **PHI** to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.

As required by Law: We will disclose your **PHI** about you when required to do so by international, federal, state, or local law.

Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your **PHI**, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights regarding your protected health information.

The Right to Inspect and Copy: Under federal law you have the right to inspect and copy your **PHI** (we have up to 30 days to make your **PHI** available to you). You have a right to a Summary of your **PHI** instead of the entire record, or an explanation of the **PHI** which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

The Right to an Electronic Copy of Electronic Medical Records: You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your medical records, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request, however, if it is not readily producible by us we will provide it in either our standard format or in hard copy form.

Patient Initials: _____

The Right to Request Restrictions: You have the right to request a restriction or limitation on the **PHI** we use or disclose for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your **PHI** and by law we must comply when the **PHI** pertains solely to a health care item or service which the health care provider involved has been paid out of pocket in full. By law, you may not request that we restrict the disclosure of your **PHI** for treatment purposes.

The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured **PHI**.

The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred six years prior to the date of request. Your request must be made in writing, and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12-month period will be free. Any additional requests within that same time period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request to Receive Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

Complaints: You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing. Complaints must be submitted within 180 days of when you knew of or suspected the violation. **There will be no retaliation against you for filing a complaint.**

You have the right to request a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically.

ACKNOWLEDGMENT & AGREEMENT

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my Protected Health Information.

Please sign below to acknowledge you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Guardian, or Legal Representative

Signature: _____ Date: _____

Name (Print): _____

COMMUNITY DENTAL CLINIC

HIPAA: RECORDS RELEASE

Last Name: _____ First Name: _____ Date of Birth: _____

Phone: _____ Email: _____

I authorize **Community Dental Clinic** to share my Protected Health Information (PHI) with:

Contact: _____ Relationship: _____

Phone: _____ Email: _____

INFORMATION ALLOWED (CHECK ALL THAT APPLY)

- ☐ Appointments
- ☐ Records/X-rays
- ☐ Lab Fees
- ☐ Treatment/Procedures
- ☐ Medications
- ☐ Other: _____

PURPOSE (CHECK ALL THAT APPLY)

- ☐ Care Coordination
- ☐ Other: _____
- ☐ Treatment Discussion

EXPIRATION (CHECK ONE)

- ☐ 1 year from signature
- ☐ Until revoked in writing

ACKNOWLEDGMENT & AGREEMENT

I understand that this authorization is voluntary and I may revoke it at any time by submitting a written request to Community Dental Clinic, except to the extent that action has already been taken.

Information shared under this authorization **may be redisclosed** by the recipient and may no longer be protected under federal privacy regulations.

Patient Signature: _____ **Date:** _____

Guardian, or Legal Representative

Signature: _____ Date: _____

Name (Print): _____

COMMUNITY DENTAL CLINIC

CONSENT & RELEASE

Last Name: _____ First Name: _____ MI: _____

Please Read Carefully

I hereby authorize Community Dental Clinic and its agents to perform any tests, x-rays, study models, photographs, treatments, or medications that in their judgement are considered necessary and advisable for the detection, diagnosis and treatment of oral diseases. I understand that the use of anesthetic agents embodies certain risks.

In consideration of said present and future services, treatments and medications received to my full satisfaction from the Community Dental Clinic and without any other representation, promise or agreement, oral or written, I hereby release and discharge the Community Dental Clinic and any and all parties in interest form all claims, demands, grievances and causes of action of every kind whatsoever, including, but not limited to, all liability for damages of every kind, nature or description now existing or which may hereafter arise from or out of injuries and damages, known or unknown, permanent or otherwise, received by me at or near the Community Dental Clinic.

I hereby agree to the release of all medical reports, treatment notes, x-ray readings and other writings pertaining to the treatment I receive at the Community Dental Clinic (my medical records) to any doctor or medical facility necessary for the coordination or continuation of my care and the release of said updated medical records from the doctor or medical facility back to the Community Dental Clinic. I understand that if at some future time I request the Community Dental Clinic to forward copies of my dental records to another doctor or facility, I will be required to pay for the reproduction costs at the time I submit my request and records release form.

Acknowledgment & Agreement

By signing below, I confirm that I have read and understand this Consent & Release form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I agree to the terms outlined above.

Patient Signature: _____ Date: _____

COMMUNITY DENTAL CLINIC

PATIENT GUIDELINES

Last Name: _____ First Name: _____ MI: _____

Welcome to the Community Dental Clinic!

The Community Dental Clinic is an independent non-profit dental facility supported through donated services, private donations, grants, and fundraising. We are not a government agency.

Our goal is to partner with you to improve your oral health and help you complete your treatment as smoothly and efficiently as possible. All treatment plans are created together with your provider and reviewed with you so you can feel confident in your care.

We are committed to providing a safe, respectful, and compassionate environment. The guidelines below are designed to help you get the most out of your care and avoid delays in completing your treatment.

ARRIVE ON TIME

Arriving on time helps ensure you receive your full treatment as planned and keeps your care on track without delays. Each appointment reserves a room, provider time, and resources specifically for you.

If you need to make a change, please give at least 24 hours' notice so we can offer that time to another patient in need.

- We request that you arrive 15 minutes early for any paperwork that may need to be completed.
- Missed appointments may delay your treatment progress and ability to complete care.
- After repeated missed appointments, future scheduling may be limited.
- If you arrive more than 10 minutes late, we may need to reschedule to ensure safe and complete care.

Patient Initials: _____

CONFIRM YOUR APPOINTMENTS

As a courtesy, our office will contact you one to two days prior to your scheduled dental appointment to confirm. We may reach out by phone call or text message. If a message is left, please return our call or reply to the text to confirm your appointment. *It is highly recommended that you save the clinic phone number to your phone*.

Patients are responsible for maintaining current contact information to ensure timely communication regarding appointments, treatment, and office updates. Messages may be left after business hours, and our team will respond as soon as possible. **Appointments that are not confirmed 24 hours' in advance will be forfeited and will need to be rescheduled.**

Patient Initials: _____

PARTICIPATE IN YOUR TREATMENT PLAN

Your treatment plan is designed to help you achieve healthy teeth and gums as efficiently as possible. Following your recommended plan and attending scheduled visits helps prevent complications and reduces overall treatment time.

If you ever have questions or concerns, we are here to help and can arrange time for you to speak with our Dental Director. Working together ensures the best possible outcome for your care.

Patient Initials: _____

MISSED APPOINTMENT POLICY

A $25.00 fee will be charged for any missed appointment without prior notice (no-call/no-show). This fee must be paid in full before scheduling any future appointments. Three missed appointments will result in dismissal from our practice.

To avoid the $25.00 administrative fee and the cancelation of future appointments, please notify our office of any changes or cancellations at least 24 hours in advance.

As a non-profit organization, these policies help us make the best use of our limited resources and ensure our providers can serve as many patients as possible.

Patient Initials: _____

RESPECT OUR TEAM AND VOLUNTEERS

Our providers and staff generously give their time to deliver quality care at no cost to you. A respectful and positive environment helps us provide the best experience for everyone.

If you have concerns, please let a team member know. We are happy to listen and help.

If you are referred to an outside provider, completing that appointment is an important part of your treatment. Missing outside referrals may delay your care and limit future referral options.

Patient Initials: _____

FOLLOW CLINIC GUIDELINES

These guidelines help us maintain a safe, comfortable space for your care:

- Only patients are allowed in treatment areas (assistance available upon request for special needs).
- Please silence your phone during treatment to minimize interruptions.
- To protect patient privacy, photos and videos are not permitted in the clinic.

Patient Initials: _____

ACKNOWLEDGMENT & AGREEMENT

By signing below, I acknowledge that I have read and understand the Community Dental Clinic Patient Guidelines. I agree to follow these guidelines so I can receive care in a timely and effective manner.

I understand that these guidelines are in place to support my treatment and the care of all patients. I also understand that failure to follow these guidelines may result in delays in my treatment, changes to my scheduling privileges, or dismissal from the clinic. The Community Dental Clinic reserves the right to decline or discontinue care if these guidelines are not followed.

Patient Signature: _____ **Date:** _____