Health History Form
Coulee Region Implant and Oral Surgery Center
Leslee Timm, DDS, Charles Polzin, DDS, Adam Sorenson, DDS

Patient's Name ____ Date of Birth _____/_____/_________

Gender: Male ______ Female ______ Height: ___________ Weight: _________

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please **circle** your responses.

Please describe your current general health: **Excellent** **Good** **Fair** **Poor**

Please describe why you are here today: ____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: ____

Are you now under a physician's care for a particular problem at this time: Yes No
If yes, why? ____ Date of Last Physical Exam ____/____/________

Have you ever been hospitalized, had any surgeries, or had a serious illness? Yes No
If yes, why? ____

____

____

PATIENT MEDICAL HISTORY
Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker, swollen ankles)?	Yes	No
Can you walk up a flight of stairs without shortness of breath or chest pain?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No
Thyroid disease?	Yes	No
Stomach ulcers or colitis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No
Frequent or recurring mouth sores?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No
Osteoporosis or Osteopenia?	Yes	No
Do you have sleep apnea?	Yes	No
Do you wear contacts?	Yes	No
Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Glaucoma?	Yes	No
Bleeding disorder, anemia, bleeding tendency, blood transfusion?	Yes	No
Do you bruise easily?	Yes	No
Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Diabetes? **Type 1___ Type 2___**	Yes	No
Arthritis?	Yes	No
Significant weight loss or gain?	Yes	No
Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Sinus or nasal problems?	Yes	No
HIV	Yes	No

Any disease, chemotherapy or transplant operation? Cancer?
If so, where? ____. Date of last treatment? ______________________
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No
If yes, please explain:

____

____

FAMILY MEDICAL HISTORY
Do you have a family history of any of the following? If yes, indicate the relationship.

Anesthesia Complications?	Yes	No	Relationship _______________
Diabetes?	Yes	No	Relationship _______________
Bleeding problems?	Yes	No	Relationship _______________
Tumors?	Yes	No	Relationship _________________
Cancer?	Yes	No	Relationship _________________
Lung disease?	Yes	No	Relationship _________________

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FEMALE PATIENTS: Are you pregnant or is there any chance you might be pregnant? Yes No

MEDICATIONS
Are you using any of the following? Please List

Do you need a Pre-Med before dental work? Yes No

Are you on Blood Thinners?________________ Yes No

Antibiotics? ______________________________ Yes No

Heart drugs?_____________________________ Yes No

Steroids (cortisone, prednisone, etc.)?________ Yes No

Antianxiety agents, sedative-hypnotics and Antidepressants? ________________________ Yes No

Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?______________________________ Yes No

Prescription Pain Medication?______________ Yes No
If Yes, Drug Name, How Long, Oral or IV?

____

Insulin or Oral anti-diabetic drugs?___________ Yes No

High blood pressure medications?___________ Yes No

Bisphosphonates, antiangiogenic and/or Antiresorptive medications for osteoporosis, multiple myeloma, or other cancers?
If yes, list drugs used and time of use. Yes No

____

Please list any other medications you have taken or are currently taking <u>not listed above</u> including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

____
____
____

ALLERGIES
Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food Products? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or Ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Other drug allergies not listed above: ____

SOCIAL HISTORY
Have you ever smoked? Yes No If yes, how much and for how long? ______________________
Have you ever chewed tobacco? Yes No If yes, how much and for how long? ______________________

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How Often? ________________

Marijuana? Yes No How Often? ________________

Recreational drugs? Yes No How Often? ________________

DENTAL HISTORY
Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? ______________________

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_______________________________________ _______________________
Signature of patient, parent, guardian Date

_______________________________________ _______________________
printed name of patient, parent, guardian Relationship

HEALTH HISTORY UPDATE

Date	Comments	Signature
________	______________________	______________________

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PATIENT REGISTRATION FORM

PATIENT INFORMATION **Current Date** ___________________

Dr. Mr. Mrs.
Miss. Ms _______ Name ____
First M.I. Last

Address ____ City ___________________ State _______ Zip_________

Home Phone ( ) __________________ Cell Phone ( ) _______________ Work Phone ( ) _________________

Date of Birth ___________ Male ____ Female ____ Age ____ Marital Status ____ Pt. SS #______________________

Email ____ Occupation ______________________________

Place of Employment/School ____________________________Emergency Contact ______________________Phone____________

Physician________________ Dentist__________________ Orthodontist __________________ Referred by ___________________

Email: ____

FINANCIALLY RESPONSIBLE PARTY (If you are over 18, you are financially responsible)

CHECK if same as above ________ (If checked, skip to next section)

Name ____ Relationship to Patient _________________

Address ____ City ___________________ State _______ Zip ___________

Home Phone ________________ Cell Phone ________________ Date of Birth ________________ SS # ___________________

Place of Employment_____________________ Work Phone ___________ Occupation _____________ Email___________________

INSURANCE INFORMATION

Please bring insurance cards or a copy, if available

INSURANCE #1

☐ Dental Insurance ☐ Medical Insurance ☐ Both (Dental/Medical through same Carrier) ☐ Medical Assistance

Policyholder Name ________________________________ *Date of Birth* ___________ *SS #* ______________________

Complete the following only if we do NOT have a copy of your insurance card. **(We do not have access to Mayo Clinic Ins. Info.)**

Insurance Company Name ____Phone Number _______________________

Insurance Company Address ____State_______Zip___________

Patient's Insurance ID Number _____________________________________ Group Number ______________________

Please complete below ONLY if the Policyholder is someone OTHER than the patient.

Policyholder Address ______________________________ City ___________________ State _____ Zip ______________

Policyholder's Employer ____ Work Phone __________________

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. I have read this statement and certify that the information is correct.

I hereby authorize insurance payments otherwise payable to me to be paid directly to Drs. Anderson & Durtsche, Ltd. I also authorize release of any information necessary to process an insurance claim.

X X

SIGNATURE OF PATIENT, PARENT or GUARDIAN IF MINOR **DATE**

INSURANCE #2

☐ Dental Insurance ☐ Medical Insurance ☐ Both (Dental/Medical through same Carrier) ☐ Medical Assistance

Policyholder Name ________________________ *Date of Birth* __________ *SS #* ________________

Complete the following only if we do NOT have a copy of your insurance card. **(We do not have access to Mayo Clinic Ins. Info)**

Insurance Company Name ________________________ Phone Number ________________

Insurance Company Address ________________________ State______ Zip________

Patient's Insurance ID Number ________________________ Group Number ________________

Please complete below ONLY if policyholder is someone not already listed as a subscriber.

Policyholder Address ________________________ City ____________ State _____ Zip __________

Policyholder's Employer ________________________ Work Phone ________________

INSURANCE #3

☐ Dental Insurance ☐ Medical Insurance ☐ Both (Dental/Medical through same Carrier) ☐ Medical Assistance

Policyholder Name ________________________ *Date of Birth* __________ *SS #* ________________

Complete the following only if we do NOT have a copy of your insurance card. **(We do not have access to Mayo Clinic Ins. Info)**

Insurance Company Name ________________________ Phone Number ________________

Insurance Company Address ________________________ State______ Zip________

Patient's Insurance ID Number ________________________ Group Number ________________

Please complete below ONLY if policyholder is someone not already listed as a subscriber.

Policyholder Address ________________________ City ____________ State _____ Zip __________

Policyholder's Employer ________________________ Work Phone ________________

INSURANCE #4

☐ Dental Insurance ☐ Medical Insurance ☐ Both (Dental/Medical through same Carrier) ☐ Medical Assistance

Policyholder Name ________________________ *Date of Birth* __________ *SS #* ________________

Complete the following only if we do NOT have a copy of your insurance card. **We do not have access to Mayo Clinic Ins. Info)**

Insurance Company Name ________________________ Phone Number________________

Insurance Company Address ________________________ State______ Zip________

Patient's Insurance ID Number ________________________ Group Number ________________

Please complete below ONLY if policyholder is someone not already listed as a subscriber.

Policyholder Address ________________________ City ____________ State _____ Zip __________

Policyholder's Employer ________________________ Work Phone ________________

PLEASE RETURN THIS SIGNED FORM TO THE RECEPTIONIST
AT YOUR APPOINTMENT TIME.

ACKNOWLEDGEMENT

I have received a copy of this office's **Notice of Privacy Practice**.

____

Print Patient Name

____ ____________________

Signature of Patient or Parent/Guardian Date

____

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practice Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to persons involved in your care and payment for your care. (See sections "To Your Family and Friends" and "Persons Involved in Care" in the Notice of Privacy Practices). We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Privacy Officer listed on the Notice. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

____

Print Patient Name

____ ____________________

Signature of Patient or Parent/Guardian Date