Today's Date:_____

Patient Dental & Medical Health History Information

Welcome to our office. Please answer the following questions. Remember that the answers to these questions are held confidential. NOTE: If a patient is a minor, write information of responsible adult in last section of patient information.

PATIENT INFORMATION		
Last Name:	First Name:	Middle Name:
Home phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address: City:	State:	Zip:
Date of Birth: / /	Social Security Number:	
Gender:	Marital Status:	
Employer:	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:	
DENTAL HISTORY AND SYMPTOMS		
What is the reason for you visit today?		
When was your last dental exam?	Last dental x-rays?	
Have you ever had problems with dental treatment in the past?..... Yes No If yes, describe what happened?		
Have you ever had abnormal bleeding after dental treatment, cuts or surgery?.....Yes No		
Have you ever had a reaction or problem with dental anesthesia?..... Yes No If yes, describe what happened?		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES		
Are you taking any **blood thinners** (such as Coumadin, Warfarin, Xarelto, Pradaxa, Plavix (clopidogrel), heparin or aspirin?.....Yes No If yes, which medication are you taking?_____		
Are you taking any medication to treat **osteoporosis** or Paget's disease?.....Yes No Some commonly prescribed drugs are alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), zolendronate (Reclast), and denosumab (Prolia) If yes, which 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?.....Yes No If yes, which medication are you taking?_____		
Are you taking hormone replacement?..... Yes No		
Are you taking any other prescriptions or over the counter medications?..... Yes No If yes, write on the back of this sheet which medications, dosages and frequency or attach list.		
WOMEN ONLY: Are you:		
Taking birth control pills?.....Yes No		
Pregnant? If yes, number of weeks and due date?_____.....Yes No		
Nursing?..... Yes No		

Please list all medications here:

ALLERGIES

Are you allergic to or have had an allergic reaction to: Circle below if applicable.

Aspirin
Barbiturates, sedatives or sleeping pills
Codeine or other narcotics
Iodine
Latex (rubber)
Local anesthetics
Metals
Penicillin
Sulfa drugs
Other antibiotics:_____
Any other medications: _____
If you answered yes to any of these, describe what happened? _____

MEDICAL AND SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure? /

Doctor's Name:

Phone:

Please circle your answers to the following questions.

Are you in good health?..... Yes No

Are you undergoing any medical treatment currently or will you in the next 6 months?..... Yes No

If yes, what treatment?_____

Have you ever been told that you need antibiotics before dental treatment?..... Yes No

Have you had any type of joint replacement surgery (such as hip, knee, shoulder, etc)?..... Yes No

If yes, what kind and when?_____

Have you had a heart valve replacement and heart surgery?..... Yes No

If yes, what kind and when?_____

Have you ever had an organ or bone marrow/stem cell transplant?..... Yes No

If yes, what kind and when?_____

MEDICAL HISTORY SPECIFIC

If you have or have you ever been diagnosed with any of the following conditions? Circle below if applicable.

Heart Health
High blood pressure
Pacemaker/defibrillator
Artificial/prosthetic heart valve
Previous infective endocarditis
Damaged heart valves
Heart valve repair
Congenital heart disease
Coronary artery disease
Congestive heart failure
Heart attack
Heart murmur
Heart rhythm disorder
Rheumatic heart disease

Respiratory Health
Asthma or COPD
Emphysema
Sinus trouble
Tuberculosis

Cancer
Type:_____
Date of diagnosis:_____
Chemotherapy? _____
Radiation?_____

Blood Health
Anemia
Blood transfusions
Hemophilia
Frequent nose bleeds
Easy bleeding or bruising
Frequent infections
Immune deficiency

Neurological/Mental Health
Seizures or epilepsy
Stroke
Neurological disorder
Mental health disorder

Autoimmune disease
AIDS or HIV infection
Lupus
Rheumatoid arthritis

GI/Digestive Health
Stomach ulcers
GI Disease

Eye Health
Glaucoma
Eye related issue

Other
Diabetes (Type I or II)
Arthritis
Liver disease
Kidney disease
Thyroid disease
Sexually transmitted infection (STI)

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

Signature of Patient/Legal Guardian: Date:

Office use only: Medical Alert Premedication Allergies Anesthesia

HM Family Dental, LLC

General Consent

Please read all pages and initial the first two pages at the bottom. Sign the last page.

I authorize Dr Hasim Momin and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, teeth, gums and surrounding tissues may remain sensitive or even possibly quite painful both during and after completion of treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required. Dental materials and medications may trigger allergic or sensitivity reactions.

I understand that as part of dental treatment, items including but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary, and I have been given the opportunity to ask questions.

Please read the following and ask questions if any arise.

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle, automobile or hazardous devices; or work while taking such medications and/or drugs; until fully recovered from the effects of same. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-

healing of the jaw bones following oral surgery or tooth extractions. I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working in the oral cavity that were not discovered during the initial examination, including but not limited to root canal therapy following routine restorative procedures. I give my permission to the dentist or such associates or assistants to make any or all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT (TMJ) AND TMJ DYSFUNCTIONS (TMD)

I understand that after lengthy appointments, jaw muscles may be sore or tender and symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. However, symptoms of TMJ associated with dental treatment are usually temporary in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment.

5. FILLINGS AND RESTORATIONS

I understand that care must be exercised in chewing on the new filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling.

6. REMOVAL OF TEETH (EXTRACTION)

If removal of teeth is indicated as a treatment option, an alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to perform treatment as deemed necessary. I understand removing teeth does not always remove all infection if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, a fractured jaw, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for a period of time or in rare cases could be permanent. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

7. CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of 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 realized that the final opportunity to make changes in my new crowns, bridge or veneer (including shape, fit, size, placement, and color) will be done before cementation. I understand, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be

predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES – COMPLETE AND PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. I understand the potential problems of wearing those appliances, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after.

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from treatment and that occasionally root canal filling material may extend through the root, which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT

I understand that if I have a serious condition causing gum inflammation and/or bone loss, it can lead to the loss of my teeth. If treatment of periodontal disease is indicated, an alternative has been explained to me including nonsurgical cleaning, gum surgery and/or extractions. I understand the success of treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoiding tobacco products and following other recommendations.

I understand that dentistry is not an exact science; therefore, reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have been recommended, requested and authorized. I understand that if complications arise as a result of treatment and require further evaluation and additional treatment, I am responsible for the costs. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment. This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____

HM Family Dental, LLC

Financial Policy

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We will communicate all recommended treatment options and associated fees prior to the start of treatment.

In compliance with the Truth in Lending Law, please be advised that our payment policy is as follows:

PATIENTS WITHOUT DENTAL INSURANCE: PAYMENT IN FULL is due at the time of service. On reconstruction cases, (crowns, bridges and partials) 90% of the fee is due at the time treatment begins, and the balance is due at the time of insertion.

PATIENTS WITH DENTAL INSURANCE: We will submit your claim to your insurance company if allowed. You will be required to pay any applicable deductibles and estimated copayments at the time of treatment. You will be responsible for any portion not paid by your insurance company. If, after 60 days, your insurance company has not paid the claim, it is your responsibility to pay the outstanding balance. If you have a direct reimbursement policy, payment in full is expected on the day of service, and you can work with your dental plan to reimburse you. *You (not the insurance company) are responsible for the fees of service rendered.*

We accept cash, checks and credit cards including Visa, MasterCard, Discover and American Express. There will be a $25.00 charge for returned checks. A finance charge of 1.5% per month will be charged for accounts over 30 days past due. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient. The parent(s) or guardian(s) for a minor child are responsible for payment of services rendered to the minor.

We are committed to respecting your time and ask that you make every effort to keep your appointment time which is reserved exclusively for you. Should you find it necessary to reschedule an appointment, please provide us with at least a 24-hour notice to avoid being charged a missed appointment fee of $75.00.

I understand and agree to the policies above. By my signature below, I authorize the following: (1) Release of any information to process insurance claims; and, (2) payment or benefits will be directly secured by HM Family Dental, LLC. I accept full financial responsibility for all charges for services or items provided, and I have read and agree to the financial policy as listed above.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

HM Family Dental, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

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

Patient Name (Print): _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please specify below)

_____