New Patient Registration Form

Please complete all the information and bring it with you to your office visit.

Personal Information

Last Name:	First Name:	Middle:	Suffix:
Date of Birth:	SSN:	Preferred Language:	
Sex: Female( )Male( )Marital Status: Divorced( )Married( )Separated( )Single( )Widow/Widower ( )			
Ethnicity: American Indian/Native American ( ) White ( ) Black/African American ( ) Asian ( ) Pacific Islander ( ) Hispanic or Latino ( ) Don't know or Declined to answer ( )			
Email:		Place of Birth:	
Do you have an Advanced Directive? Yes ( ) No ( ) Do you have a Power of Attorney? Yes ( ) No ( )			
Would you like information regarding an Advanced Directive? Yes ( ) No ( )			
Internet Access? Yes ( ) No ( ) If yes, where at? Home( ) Work( ) School( ) Other ( )			
Religious Preference:			

Demographics

Physical Address:	City:	State:	Zip:
Mailing Address (If different):	City:	State:	Zip:
Present Community:	Date moved to community:		
Home Phone:	Cell Phone:	Message Phone:	
Do we have permission to send text message regarding appointments reminders and clinic updates? Y / N			

Emergency Contact:

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone:	Work Phone:		

Next of Kin:

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone:	Work Phone:		

Employment History

Employer Name:	Work Phone:		
Address:	City:	State:	Zip:
Status: Full-time ( ) Part-time ( )	Estimated Monthly Family Income: $	#In Household:	

Parent/Legal Guardian:

Parent/Legal Guardian #1:	Birthdate:	Birthplace:
Employer :	Phone #:	
Type of Guardian: Biological ( ) Adoptive ( ) Foster ( ) Other:		
Parent/Legal Guardian #2:	Birthdate:	Birthplace:
Employer:	Phone#:	
Type of Guardian: Biological ( ) Adoptive ( )Foster ( ) Other:		
Mother's Maiden Name:		

Native American Descendancy

Are you of Native American descendancy? Yes ( ) No ( )	Indian Blood Quantum:	
Tribal Membership:	Tribe Quantum:	Tribal Enrollment Number:

*****BRING ALL TRIBAL IDENTIFICATION WITH YOU TO YOUR APPOINTMENT – WE WILL NEED TO SCAN THEM INTO OUR RECORD***** To Prove Descendancy: Parents Indian Verification/Patient Birth Certificate Tribal Documentation: Grandparents Indian Verification/Parents County Birth Certificates/Patient Birth Certificate

Veteran Status:

Are you a Veteran? Yes ( ) No ( )	If yes, which branch?
Valid VA Card? Yes ( ) No ( )	Please give card to registration clerk.

Migrant/Homeless:

Migrant worker? Yes( ) No( )Migrant Worker Type: Migrant Ag Worker( ) Seasonal Migrant Worker ( )
Are you Homeless? Yes( )No( )Homeless Type: Homeless Shelter( )Street( )Transitional( )Other( )

Insurance/Guarantor:

#1 Company Name:			Phone:
Address:	City:	State:	Zip:
Policy Holder Name:	Relationship:		
Policy Number:	Coverage Type:		
Eligibility Start Date:	Member Number:		
#2 Company Name:			Phone:
Address:	City:	State:	Zip:
Policy Holder Name:	Relationship:		
Policy Number:	Coverage Type:		
Eligibility Start Date:	Member Number:		

**** BRING ALL INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT – WE WILL NEED TO SCAN THEM INTO OUR RECORD ****

Print Name:	
Signature:	Date:
Relationship to Patient:	

By signing here you are agreeing that the details given on this form are true and correct.

Office use Only:
Received by:_____ Date:_____
Scanned by:_____ Date:_____

MRN:_____

Patient Financial Responsibility

Agreement

We feel that a part of good health care is having a clear financial policy that is shared with our patients. Please take time to review this policy. We want to make sure you understand it. Financial details can be confusing. Let us know if you need us to explain anything.

If you are Native American /Alaskan Native you may qualify for special benefits and some of this information will not pertain to you.

Payment: Here are some details that you should know about our payment policy.

Any fees that you need to pay are due at the time of your visit. This policy is for patients with or without health insurance.
We will take cash check or credit card.
If you have insurance, your payment includes any unpaid: *Deductibles *Co-insurance *Co-payment amount *Non-covered fees from your insurance company
We ask for a copy of an ID card or license to help protect you from identity theft.
Self-Pay, Sliding fee scale: Did you know that we have a sliding fee for patients that qualify? Please ask for more information.

Insurances: Here are some details that you should know about insurance.

We are participating provider or considered "in-network" with a few insurance plans; find out if we are with your plan by contacting your insurance company.
Learn what services and clinicians are covered before you visit by calling your insurance benefits department.
If our clinicians or services are not listed in your plan's network (on their list of clinicians or services they have a contract with): *You may have to pay for part of, or the entire bill. *We will send the claim to your insurance for you. *Your insurance might send the payment for you to bring and pay at your PRHS visit.
You must bring your insurance card to every visit. We will need to copy both sides.
If you have insurance, we will send them a bill.
If the insurance does not cover the fees the patient will need to pay. If we get a payment from insurance you pay, we will refund what is due to you.

If you are a member of a HMO or managed care plan:
You must see your primary care provider (the clinician you see for your general health care).
If your insurance does not cover part of your fee:
You might qualify for our sliding fee discount program for the things that are not covered Medical and dental have different rules.

Other Notes: Here are some things to think about:

Diagnostic test are billed separately.
If you are referred to another provider or other services, any bills or fees you get from them will be between you and them. They may bill differently than we do at PRHS.

If you have any question about your bill or fees. Our billing team is willing to help you. Call 530-335-3651

Sign Here: By signing you are saying that you agree to the statement in the box.

I have read and understand the details of the PRHS Financial Policy and authorize PRHS to bill my insurance.
Patient Name:_____ Date:_____ Sign (patient or account holder):_____ Print Name:_____

YOUR PRIVACY OPTIONS
Receipt of Privacy Practices & HIPAA Authorization

This form is to help us know what details, if any, you would like us to share with the people in your life. You can also tell us how you want information shared. Telling PRHS how you want to share information is called HIPAA Authorization and it's from the Health Insurance Portability and Accountability Act (HIPAA). This form also helps us to know that we have asked to give you our privacy practices.

Personal Details: Tell us about yourself or the person this form is for.

Last Name:_____ First Name:_____ Middle Initial:_____
Nickname:_____ Date of birth:_____

Name of Parent, Legal Guardian, or Conservator: (Only if any of these apply to you.)
_____

Messages: This is where you tell us if we can leave you voice messages and what we can share.

You allow PRHS To:
____ Leave voice messages at the phone number you've given us.
____ Leave voice messages about your appointments at the phone numbers you've given us.
____ Leave voices messages about labs or tests results at the phone numbers you've given us.

If you do not want ANYTHING told or shared with ANYONE check and sign here:___
Signature:_____

Who to share with and what we can share: This is where you tell PRHS who you would like us to share, or release information with. Each box is for different person.

Who can we share your information with? (Optional)

Person #1:_____DOB:_____Relationship:_____

With this person, you allow PRHS to:
____We can tell this person any and all of my medical information.
____We can give this person today's chart notes at the time of the visit.
____We can give this person all of your test results.
____This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: ___Medical/Dental visits ___Immunizations(This person must bring ID in at the time of visit)

Who can we share your information with? (Optional)

Person #2:_____DOB:_____Relationship:_____

With this person, you allow PRHS to:

____We can tell this person any and all of my medical information.

____We can give this person today's chart notes at the time of the visit.

____We can give this person all of your test results.

____This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: __Medical/Dental visits ___Immunizations(This person must bring ID in at the time of visit)

Who can we share your information with? (Optional)

Person #3:_____DOB:_____Relationship:_____

With this person, you allow PRHS to:

____We can tell this person any and all of my medical information.

____We can give this person today's chart notes at the time of the visit.

____We can give this person all of your test results.

____This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: __Medical/Dental visits ___Immunizations(This person must bring ID in at the time of visit)

Sign & Initial Here:

Print name here_____

Sign:_____**Date:**_____

I was asked if I wanted a copy of PRHS's Notice of Privacy Practices._____(Initial)

Parent/Guardian/Conservator:

Sign:_____**Date:**_____

*****This approval ends one year from the date signed or updated in writing*****

Office use Only:

Received by:_____Date:_____

Scanned by:_____Date:_____

MRN:_____

PIT RIVER HEALTH SERVICE
36977 PARK AVE
BURNEY, CA. 96013

MEDICAL/DENTAL CLINIC
(530) 335-3651
(800) 843-7447

ADMINISTRATIVE OFFICE
(530) 335-5090
FAX (530) 335-5241

PRC DEPARTMENT
Boqueta (530) 335-0662
Lori (530) 335-0328
Carol (530) 335-0325
FAX (530) 335-5064

Acknowledgement of Receipt of PRHS Notice of Privacy Practices

I hereby acknowledge that I received Pit River Health Service Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

Signature of Patient or Patient Representative: _____

Relationship if Patient is a minor: _____

Signature of PRHS Employee: _____

Date: _____

HRN: _____

Medical/Dental Clinic
36977 Park Avenue
Burney, CA 96013
(530) 335-3651
(800) 843-7447

Administrative Office
369977 Park Avenue
Burney, CA 96013
(530) 335-5090
Fax: (530) 335-5241
FTS: (530) 551-5091

(RPMS AOB & ROI) Patient Consent:

This agreement is entered into by and between Pit River Health Service, Inc. and _____, the patient or guardian in order for the patient/minor to obtain:

1. **Health Care:** including medical examination, routine laboratory studies, x-ray procedures and skin tests.
2. **Dental Care:** including dental examinations, preventative use of fluorides, x-rays and necessary emergency dental care.
3. **Mental Health Service:** including evaluation and treatment as necessary.
4. **Transportation:** to and/or from another health facility or home for their services.

Terms of Agreement:

1. **The Treatment Authorization:** The patient, responsible relative or agent authorizes the health care providers at Pit River Health Service to treat him/her as required and appropriate under California Administrative Code, Title 16, section 1399.510.
2. **Authorization to Pay:** The Patient gives permission to Pit River Health Service to bill or receive direct payment for services renders from appropriate and available payment sources. Charges will not exceed that which is reasonable and customary.
3. **Release of Information:** The patient gives permission to Pit River Health Service to release information concerning him/her to insurers, other agencies or individuals that may provide medical or social services to the patient in the future.
4. **Patients Rights:** The patients' rights have been given to the patient by the Pit River Health Service staff.
5. **Contact by Phone:** The Patient gives express consent for Pit River Health Service to contact them by telephone regarding their care or appointments.
6. **Certification:** The patient, responsible relative or agent, certifies that he/she has read the foregoing and is willing to abide by these agreements.

A minor is a person under the age of 18 and must have the signature of a parent or legal guardian prior to receiving treatment.

Patient: _____ Signature: _____

(If Patient is under 18, the above signature is that of parent or legal guardian of minor who has primary responsibility for care; gives consent for the above services.)

Date: _____ _____

Updated 4/7/2021 BG

Medical/Dental Clinic
36977 Park Avenue
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(530) 335-3651

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Pit River Health Service
Medical Appointment and Failed Appointment Policy

The Pit River Health Service Medical Clinic is here to serve the needs of the community. We ask you to please arrive 15 minutes early to update your information and to fill out any necessary paper-work. If you are 10 minutes late, your appointment we will have to be rescheduled and will count as a failed appointment. By showing up to your appointment early ~~you~~ will help us in providing you with the very best quality health care.

When appointments are cancelled, without at least 4 hours advance notice, we are unable to offer this time to another patient who is in need of our services. A less than 4 hour cancel notice or not showing up for a scheduled appointment would be considered a failed appointment. Our failed appointment policy will be enforced as follows:

The receptionist may contact a nurse to triage each request for urgent care to determine whether there is a true urgency for medical care exists and to assure that chronic health issues receive proper continued care. The nurse will determine if there is a valid excuse for missing an appointment in which case this policy may be waived.

You will not receive another scheduled medical appointment until you have attended a clinic session for standby care at 8:00 a.m. and 1:00 p.m.to standby for your missed medical visit. When another patient fails to show up,you will be given the appointment visit. If the last patient of the morning or afternoon session arrives and you have not already been seen, an appointment will be made for you. Thank you for assisting us in keeping all Pit River Health Service appointment times filled.

Walk-in emergency times are 8:00 a.m.,1:00 p.m. and 4:00 p.m. If possible, please call before you come in so that we can prepare for your arrival.

To assist Pit River Health Service in maximizing your services to the community, I hereby agree to give 4-hour notice of a cancelled appointment by phone or by voice message. I understand the scheduling restrictions if I fail to give adequate notice of cancellation.

Patient Signature: _____ Date: _____

CEO: Loren Ellery Date: 7/10/24

Board Approved: Jamie Daugherty Date: 7/3/2024

Legislative History: Amended by the PRHS Board of Directors On May 28,2024

Pit River Health Service Inc
Medical/Dental/Behavioral Health Clinics
36977 Park Ave Burney CA 96013
(530)-335-3651
Release of Information

PLEASE FAX ALL COPIES TO PRHS MEDICAL RECORDS (530)335-3221

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

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

I hereby authorize: _____

Address: _____

Phone: _____ **Fax:** _____

To disclose my protected health information listed below to: (clinic/hospital, person, etc.)

Name: _____

Address: _____

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

Phone: _____ **Fax:** _____

INFORMATION TO BE RELEASED

Dates of Service: _____

- ☐ History and physical exam
- ☐ Lab report
- ☐ X-ray report
- ☐ Consultation report
- ☐ Behavioral Health/Psych Must Initial _____
- ☐ Other _____

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Second Opinion
- ☐ Continuing Care
- ☐ At patient request
- ☐ Workers' Comp
- ☐ Legal
- ☐ Insurance
- ☐ School
- ☐ Other _____

1. I understand that this authorization will expire two years from date signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer, in writing, at Pit River Health Service, Inc. and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care will not be affected if I do not sign this form. My PRC and/or 3rd party funds can be affected if I choose not to sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I request that the records identified above be handled in the following manner:
☐ Mail to Address Listed Above ☐ I will pick ☐ Fax# above/Attn: _____

☐ A Representative will pick-up on my behalf. (Valid ID is required)

Representative Name: _____ DOB: _____

7. I understand that I will get a copy of this form after I sign it upon request.
By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____

Signature of Patient **Date** **Parent/Legal Guardian/Authorized Person** **Date**

_____

Relationship to Patient

PLEASE FAX ALL COPIES TO PRHS MEDICAL RECORDS (530)335-3221

Please note: The Information contained in this report may be privileged, confidential and protected from disclosure. If the reader of this is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited by law. If you have received this communication in error, please notify the sender immediately and destroy his copy. Call 530-335-0323 if you have received this in error.

For Office Use Only

Date Request Filled _____ By _____, _____
Printed Name Title

Identification Presented: ☐ yes ☐ no _____ RPMS Account #: _____
Type of Identification

Date of Release _____, See line 6 IF PICKED UP Signature required _____

HIM Signature _____

MRN: _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*

City: State: Zip:

Occupation:

Height: Weight: Date of Birth: Sex:

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort? ☐ ☐ ☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐

	Yes	No	DK
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐

	Yes	No	DK
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: