HEALTH HISTORY

DEMOGRAPHICS

Name _____ Birthdate _____

SSN _____ Gender _____ Preferred Pronoun _____

Phone (cell, work, home) _____ or _____

Email Address _____

Preferred contact method (check all that apply): ❑ Cell ❑ Text ❑ Email ❑ Home Phone ❑ Work Phone

Address _____

City _____ State _____ Zip _____

How did you hear about us? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

❑ Yes ❑ No Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?

❑ Yes ❑ No Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?

❑ Yes ❑ No Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?

❑ Yes ❑ No Bleeding disorder, anemia, bleeding tendency, blood transfusion?

❑ Yes ❑ No Do you bruise easily?

❑ Yes ❑ No Kidney disease or kidney failure, requiring dialysis?

❑ Yes ❑ No Liver disease (jaundice, hepatitis A, B, or C)?

❑ Yes ❑ No Thyroid disease?

❑ Yes ❑ No Arthritis?

❑ Yes ❑ No Stomach ulcers or colitis?

❑ Yes ❑ No Significant weight loss or gain?

❑ Yes ❑ No Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?

❑ Yes ❑ No Seizures, convulsions, epilepsy, fainting or dizziness?

❑ Yes ❑ No Frequent or recurring mouth sores?

❑ Yes ❑ No Sinus or nasal problems?

❑ Yes ❑ No Glaucoma?

❑ Yes ❑ No Diabetes?

❑ Yes ❑ No Sleep apnea?

❑ Yes ❑ No Osteoporosis or osteopenia?

❑ Yes ❑ No Any cancer, radiation, or chemotherapy?

Describe: _____

Date of your last treatment? _____

❑ Yes ❑ No Do you have any other disease, condition or problem not listed above that you think the doctor should know about?

If yes, please explain _____

_____

DENTAL HISTORY

❑ Yes ❑ No Have you had any adverse effects from dental treatment?

If Yes, please explain? _____

SOCIAL HISTORY

❑ Yes ❑ No Have you ever smoked, vaped or chewed tobacco? If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

❑ Yes ❑ No Substance abuse?

❑ Yes ❑ No Emotional disorders?

❑ Yes ❑ No Alcoholism?

Do you use:

❑ Yes ❑ No Alcohol? How Often? _____

❑ Yes ❑ No Marijuana? How Often? _____

❑ Yes ❑ No Recreational Drugs? How Often? _____

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 or guardian _____ Date _____

Printed Name _____ Signature _____

DENTAL INSURANCE

Insurance Company _____

Insurance Company Address _____

Insurance Company Phone Number _____

Subscriber Name _____

Subscriber D.O.B. _____

Subscriber SSN _____ Insurance Subscriber # _____

ALLERGIES

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

❑ Yes ❑ No 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 Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation?

If yes, which anesthetic? _____ Relationship? _____

Other allergies not listed above: _____

MEDICATIONS

Please list all medications _____

_____

_____

_____

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Please fill out sections 1 through 4 and sign below

Patient Name _____ D.O.B. _____

Dr. Kleive's office is authorized to release protected information about the above named patient to entities indicated below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Email Address _____

1 Appointment Information (check all that apply)

Office may send appointment information by ❑ text ❑ email ❑ postcard

❑ Office may leave appointment information on home answering machine

❑ Office may leave appointment information on cell phones listed _____

❑ Office may leave appointment information only with _____ (names)

2 Financial Information

Office may discuss billing / financial information with _____

3 Medical Information

Office may discuss Medical / Dental information with _____

4 Insurance Filing

Office may disclose my personal information to insurance for the purpose of filing claims on my behalf for services rendered at Mark Kleive, DDS, PA.

Signature of patient or personal representative _____ Date _____

Rights of Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Mark Kleive, DDS, PA or to the Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

Signature of patient or personal representative _____ Date _____