Beachton Denture Clinic
2515 U S Hwy 319 South
Thomasville, GA 31792-0439
(229)377-6588

Medical & Dental History Form

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◡ Male ◡ Female Family Status: ◡ Married ◡ Single ◡ Child ◡ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Social Security No.

_____

How did you first learn about our practice?

* ☐ Magazine ☐ Newspaper ☐ Radio ☐ Sign
☐ Television ☐ YellowPages ☐ Friend/Relative ☐ Internet/Website
☐ Other Doctor ☐ Outside Agency

Name of person referring you to our practice:

_____

What is the reason for today's visit?

*

Have you received treatment in our office previously? If so when?

*

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Are you currently wearing dentures? If yes, when did you receive your last dentures?

◯ Yes ◯ No

Do you use denture adhesives, pastes or powder? If so describe

◯ Yes ◯ No

Are you in pain or do you have sores in your mouth?

◯ Yes ◯ No

Your Primary Care Physician's name, address, & phone number:

What is the date (or approximate date) of your last medical exam?

Please list all medications you are currently taking:

Are you allergic to Latex?

* ◯ Yes ◯ No

Have you ever taken the drug Fen Phen or Redux?

* ◯ Yes ◯ No

Do you smoke cigarettes or use tobacco products?

◯ Yes ◯ No

Do you use illegal drugs? (i.e.marijuana, or cocaine)

◯ Yes ◯ No

Are you pregnant, taking birth control? Circle one

◯ Yes ◯ No

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Do you have or ever had:

teeth EXTRACTED? If so, when?

◯ Yes ◯ No

Bleeding problems?

◯ Yes ◯ No

a bad reaction to ANESTHESIA) (like Novacaine)

◯ Yes ◯ No

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ AIDS-HIV
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Latex
☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ ASPIRIN	☐ Asthma
☐ Blood Disease	☐ BLOOD THINNERS	☐ Cancer	☐ Chemical
☐ Chemotherapy	☐ Circulatory Problems	☐ Cortisone Treatment	☐ Cough, Blood produci
☐ Cough, persistant	☐ Demoral	☐ Diabetes	☐ Epilepsy
☐ Fainting	☐ Foot Swelling	☐ Glaucoma	☐ Heart Disease
☐ Heart Murmur	☐ Hemophilia	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Kidney Disease	☐ Liver Disease	☐ Mitral Valve Prolaps
☐ Multiple Myeloma	☐ Nervous Disorders	☐ Osteoporosis	☐ Pacemaker
☐ Percocet	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Shortness of Breath
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Tyelonal	☐ Ulcers
☐ Venereal Disease			

a STROKE? If so when?

◯ Yes ◯ No

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☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for all services provided. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

**We gladly accept payment by Cash, Check, Master Card, VISA, and Discover. We also offer financing through Care Credit and Lending Club (for those who qualify).

Response Date: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

for PHARMACY

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this pharmacy, _____. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTOR / TREATMENT FACILITY IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:

(This includes and any care takers, step parents, grandparents who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____