# NORTHEAST MISSOURI HEALTH COUNCIL

*Partners for a Lifetime of health*

Date:______________

Patient Name: DOB: Gender:

Address: Phone: Work phone:

**MEDICAL HISTORY**

Name of Physician: Phone:

When was your last physical?

Are your immunizations up to date? yes / no

Are you now under the care of a physician? yes / no

If yes, for what reason?

Are you presently taking any medications/drugs/pills? yes / no

Please list:

Have you ever had to be **pre-medicated** before dental treatment? yes / no

Have you ever or are you currently taking any **blood thinner** medications? yes / no

**(ie. Plavix, Xarelto, Eliquis, Pradaxa, Coumadin, Warfarin)**

Have you ever or are you currently taking any medication for:

**osteoporosis, cancer or rheumatoid arthritis?** yes / no

Have you ever or are you currently taking an **oral or IV Bisphosphonate or any of the following medications? (ie. Actonel, Boniva, Fosamax, Didronel, Prolia, Zometa)** yes / no

Are you **allergic** (or have an adverse reaction) to? **(circle all that apply below)**

Penicillin Other Antibiotic **Local Anesthetic** **Epinephrine** Aspirin None

Codeine **Latex** Other Please describe:

Are you sensitive or allergic to latex? yes / no

(i.e. Experienced itching, rash or wheezing after using latex gloves or handling a balloon)

**Do you have, or have you had any of the following: (Check boxes that apply.)**

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Artificial Joint
- ☐ Anorexia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Blood Clotting disorder
- ☐ Blood Transfusion
- ☐ Bulemia
- ☐ Cancer
- ☐ Chemo/Radiation Therapy
- ☐ Cognitive Disability
- ☐ Congenital Heart Defect
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Food Allergies
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain Management
- ☐ Recurring Otitis/Ear Infect.
- ☐ Recurring Strep
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Shingles
- ☐ Vision Impairment/Problems
- ☐ Wheezing
- ☐ Family Hx of Von Williebrand
- ☐ Hearing Impaired
- ☐ MRSA
- ☐ Neurological Disorders
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ STD/STIs
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

**Surgical History:**

Have you had any of the following surgeries listed below? **(circle all that apply below)**

Adenoidectomy    Ear tubes    Fundoplication    Gastrostomy tube

Heart Surgery    Joint Replacement    Organ Transplant    Prosthetics/Rods/Pins

Removal of Spleen    Tonsilectomy    VP Shunt

Have you had any of the other surgeries, hospitalizations or illness not listed above?

If yes, please explain: ____________________

Have you had any unusual or unexplained reactions during a surgical procedure? yes / no

If yes, please explain: ____________________

Do you currently smoke or use the following tobacco products? yes / no

Cigarettes    Cigars    Pipe    Chew    Vaping/E-Cigarettes

Have you used tobacco products in the past? yes / no

If yes, how long ago? ____________________

Do you drink alcoholic beverages? yes / no

If yes, how much? ____________________

**WOMEN:** Are you pregnant? yes / no

Are you nursing? yes / no

Do you take birth control medications? yes / no

Do you anticipate becoming pregnant? yes / no

**DENTAL HISTORY**

Date of Last Dental Visit: ____________________ OR UNKNOWN

Have you experienced/Are you experiencing any of the following? **(Check all that apply.)**

- ☐ Bleeding Gums
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets/sour
- ☐ Pain w/teeth
- ☐ Sores in/around mouth
- ☐ Head/neck/jaw injury
- ☐ Frequent headaches
- ☐ Clench/grind teeth
- ☐ Bite lips/cheeks frequently
- ☐ Clicking in jaw
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing mouth
- ☐ Difficulty in chewing
- ☐ Orthodontic work
- ☐ Prolonged bleeding following extraction

Have you ever had instruction on the correct method of brushing your teeth? yes / no

Have you ever had instructions on the care of your gums? yes / no

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**Patient Name______________________________________dob______/______/______**
**(Please Print)**

**NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:**

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: **treatment, payment, and healthcare operations.** I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Northeast Missouri Health Council, Inc. (NMHC, Inc.), has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time to receive a current copy.

**Patient/Guardian Signature__________________________ Date______/______/______**

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:**

**Assignment of insurance benefits, release of information, and authorization of treatment.** I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original. ***(If uninsured, this signature is not required.)***

**Patient/Guardian Signature__________________________ Date______/______/______**

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