Patient Registration Form

Patient Information

Date: _____

Last Name: _____ First Name: _____ MI: _____

Other/Maiden/AKA Name: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Can we text you? ☐ Yes ☐ No

Please indicate which notices you would like: ☐ Appointment Reminders ☐ Lab Results

☐ Health Maintenance ☐ Prescription Confirmation ☐ General Notices

What is the best time to reach you: ☐ Morning ☐ Afternoon ☐ Evening

Date of Birth (Month/Day/Year): ____/____/____ Preferred Pronouns: _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Transgender (Preferred Name: _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian

☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Legally Separated ☐ Widowed

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Are you employed? ☐ Yes ☐ No If yes: ☐ Full Time ☐ Part Time ☐ Other: _____

Are you a student? ☐ Yes ☐ No Highest Education Level: _____

Are you a veteran of the United States Armed Forces? ☐ Yes ☐ No

What is your living status? ☐ Housed (rent/own/shared) ☐ Transitional Housing ☐ Shelter

☐ Doubling Up (Staying with family/friends) ☐ Street ☐ Other: _____

Preferred Pharmacy: _____

Parent/Guardian Information (Patients Under 18 Only)

Last Name: _____ First Name: _____ Birth Date: _____

Phone Number: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Information

Last Name: _____ First Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information

Are you insured? ☐ Yes ☐ No

Please present your health insurance cards to the receptionist so they can scan them and attach them to your records.

Consent for Overall Treatment and Payment

I authorize any Family Healthcare licensed healthcare provider to perform such **diagnostic, telehealth/televisit, medical, counseling/mental/behavioral health, dental, optometry, and/or surgical procedures** as may be necessary for proper health care. I also give permission for administration of **medications and immunizations** as may be necessary for treatment or preventive care.

I authorize Family Healthcare and its affiliated providers to view and obtain my external prescription history. I understand that prescriptions from other unaffiliated healthcare providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Family Healthcare, and it may include prescriptions over several years.

I certify that I have read and understand the scope of my consent and that I authorize access to my prescription history.

I understand that proof of personal information may be required at any time for any reason. I will notify Family Healthcare of any changes in my health status or any of the above information. If I have provided fraudulent information, I may be subject to immediate termination of services and/or prosecution for fraud/perjury.

I understand that payment for services is due at the time of service. I understand that Family Healthcare will bill my insurance for any and all services rendered. I authorize Family Healthcare to release all or part of my/patient's record to any person or organization liable for payment. I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney's fees.

I understand that to be enrolled in Family Healthcare's federal sliding fee discount program, I must complete a Sliding Fee Discount Program Application for all wage earners in my family (self, spouse/partner, children to age 26). I understand that all sources of income, including wages, unemployment, social security, retirement, alimony, child support and disability income will be included and documented properly. If I do not provide proof of income at the time of service, I will be charged the full cost of services. I also understand that my eligibility to receive health care at a reduced rate will be reviewed every 12 months.

I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of healthcare insurance benefits be paid to Family Healthcare (Southwest Utah Community Health Center).

I have read all of the information on this registration form and have completed it to the best of my ability. I certify that this information is true and correct to the best of my knowledge.

Consent to Proceed with Dental Procedures

I authorize Family Healthcare and associated dentists, associates, and assistants as designated to perform 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 the restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or permanent (rarely) numbness. I understand that sometimes needles break and may require surgical retrieval. Sometimes drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

Consent Continued

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be scraped by accident or cut during routine dental procedures. In some cases, sutures (stitches) or more treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be 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 understand the need to tell the dentist about any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. 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 jawbones following oral surgery or tooth extractions.

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.

Patient Name	Date
Signature (Patient, Legal Guardian, or Authorized Agent of the Patient)	Date
Witness	Date

SLIDING FEE DISCOUNT PROGRAM APPLICATION

All patients are encouraged to apply for our sliding fee program. By completing this Sliding Fee Program Application form, we can determine potential savings. Even when you have insurance, we recommend you complete this form for services not covered by your insurance.

Head of Family Information

Name (Last, First, Middle Initial)		Date of Birth:	
Address:	City/State/Zip:	Home Phone:	Cell Phone:
Number of people living at home:	Marital Status (Circle One): Single Married Divorced Separated		

Family Member Information: Family includes self, spouse/partner, and children under age 26.

Name	Date of Birth	Relationship to Patient	Age	Employed
1.				Yes / No
2.				Yes / No
3.				Yes / No
4.				Yes / No
5.				Yes / No
6.				Yes / No
7.				Yes / No
8.				Yes / No
9.				Yes / No

Please submit proof of income with your application - acceptable proof of income includes:

- Tax Returns / Pay Stub
- Medicaid Eligibility Letter (Slide B)
- Unemployment Statements / Letter
- Alimony Letter / Child Support Letter
- Social Security Benefits, APA, Senior Benefits Statements
- Work Comp Benefits, Annuities, Pensions, Retirement, Rental Income Statements
- Letter of support with valuation (Family Member, Religious Leader, etc.)
- **Family Healthcare issued Vouchers on FHC letter head administered by our local partners (Slide A)**
- **Self-employed**: Please bring your current tax returns including 1099 Schedule C and/or statements of all income sources. Income is listed on: W2: Line 5, 1040:Line 9, 1099 Schedule C (1040): Line 7,1099-K Line 1a
- **Not working and living off savings:** Bring tax forms or investment income / retirement income statements.
- **Not working and receiving help from a family member/church:** Bring a letter from income source (parent, clergy, agency) stating your situation. The letter must have a dollar amount of support, name, signature, and date.

To the best of my knowledge, I certify that the above information is true and correct. I agree to inform Family Healthcare of any changes regarding my employment or financial status as soon as the changes happen.

By signing below, I give permission to Family Healthcare to enroll me in its sliding fee/discount program. I understand that if I qualify, Family Healthcare may reduce any out-of-pocket cost to me for current medical, counseling, or laboratory/diagnostic testing services. Additionally, dental, or other procedures may be discounted depending on eligibility.

If the above information proves to be incorrect, I understand that the discount provided to me will be terminated and I will be responsible for any current or prior balances. I give permission for Family Healthcare staff to contact my employer or any other appropriate source to verify income.

I understand I will be required to complete a Sliding Fee Discount application every 12 months to include Proof of Income. Proof of Income is required in order to be eligible for the Sliding Fee Discount.

Signature: _____ Date: _____

(Expires 12 months from this date)

SLIDING FEE SCALE - INCOME DETERMINATION

Family Healthcare Sliding Fee with Schedule of Discount is based on 2022 Federal Poverty Guidelines, except for Flat Fees Outlined in this Sliding Fee Policy and the Schedule of Fees Tables. Income Range will determine the percentage of fees that the patient is responsible for according to the chart below.

ANNUAL INCOME RANGE FOR THE HOUSEHOLD

Family Size	100% FPL Slide A	133% FPL Slide B*	150% FPL Slide C	Up to 200% FPL Slide D	200%=FPL Slide E	No Slide / Proof of Income
1	14,580	14,581 – 19,391	19,392 – 21,870	21,871 – 29,160	29,161+	
2	19,720	19,721 – 26,228	26,229 – 29,580	29,581 – 39,440	39,441+	
3	24,860	24,861 – 33,064	33,065 – 37,290	37,291 – 49,720	49,721+	
4	30,000	30,001 – 39,900	39,901 – 45,000	45,001 – 60,000	60,001+	
5	35,140	35,141 – 46,736	46,737 – 52,710	52,711 – 70,280	70,281+	
6	40,280	40,281 – 53,572	53,573 – 60,420	60,421 – 80,560	80,561+	

* Including Medicaid Eligible

Office Visit	$30	$40	$50	$55	Full Fees	Full Fees
Nurse Visit	$19	$20	$21	$22	$60	$60
Lab	$0	$30	$35	$40	Full Fees	Full Fees
Pharmacy	$8 (10 % Markup)	$9 (20% Markup)	$10 (20% Markup)	$11 (25% Markup)	$12 (30% Markup)	$15 (30% Markup)
Dental	$40 Nominal Fee + Supply Cost	40% Discount	30% Discount	20% Discount	0% Discount	0% Discount
Procedures	60% Discount	40% Discount	30% Discount	20% Discount	0% Discount	0% Discount

For the flat rate fee please reference table A, B, D, E, F, and I in the Schedule of Fees Tables. Services that fall outside of the flat rate fee are subject to the sliding fee range scale above.

For those without Proof of Income who have Medicaid Coverage. All patients are encouraged to apply for the sliding fee discount program and bring proof of income to determine higher discounts.

Washington County School Students/Staff: Office Visits are $10 for students, $30 for staff (not family members). Not covered by the $10/$30 fee is procedures, medications, vaccinations, labs, or behavioral health care. We encourage patients to submit insurance cards to cover additional services not covered. To be eligible for other discounts, the sliding fee discount program must be completed with proof of income.

Patient Rights and Responsibilities

Family Healthcare Provides a Patient Centered Medical Home

As your medical home, you have the rights to:

• High quality and safe healthcare team led by your personal provider with a health care team that has your health as our priority.

• Prompt appointments and communication.

• 24/7 access to records through your patient portal.

• Extended clinic hours.

• You will have prompt and easy access to your provider through:

o office visits and phone messages

o secure email — www.fhcportal.org

o website information—www.familyhc.org

• Join in decisions that improve your health and ask questions until you understand what you need to know.

• Receive care in a language you understand.

• Refuse treatment to the extent permitted by law.

• Express concern or complaints to help us improve services.

As your medical home, Family healthcare will:

• Give prompt, polite help, and respectful care which supports your values in a way that provides you with dignity and respect.

• Ensure your privacy and a safe clinic experience.

• Answer all of your questions in a language you understand.

• Respond to you in a timely and ethical manner.

• Help you move smoothly through the healthcare system.

• Offer same-day or next-day appointments as possible.

• Help you to best manage your health plan to become as healthy as possible.

• Help you understand your health needs, illnesses, treatments, and options.

• Make sure you know your medicines and how to take them correctly.

• Assess and manage your pain according to our policies. This may mean a referral to a specialist who treats pain.

• Send you to a trusted specialist, if needed.

• Provide access to emergency health care services.

• Tell you of the costs of your care and treatments.

• Collect fees so we can continue to provide health services.

• Give you your medical records when you need them and in line with privacy requirements.

• Provide teaching about Advanced Directives and Living Wills.

• Get your ideas to make your experience the best it can be.

• Tell you how to submit a complaint or grievance.

• Help you enjoy all of Family Healthcare's services.

• Remind you to respect the rights, property, and environment of all Family Healthcare providers, employees, and other patients.

Patient Responsibilities:

• Make healthy choices every day.

• Communicate in a way that we can understand your needs.

• Tell us your history & all symptoms that affect your health.

• Provide your complete medical records to Family Healthcare.

• Take your medicine and follow the health plan you and your team choose together.

• Tell us when there is a change in your health or medicine.

• Call the clinic when you have been in the hospital or the emergency department.

• Understand and follow our pain management policies.

• Keep your appointments or call early to cancel them if needed.

• Arrive 10 to 15 minutes before your appointment to sign in and fill out papers.

• Pay co-payments or fees at the time of service.

• Know your health plan coverage, benefits, and what is not covered or ask staff to help you.

• Show proof of identity, income, family size, insurance, etc. as requested.

• Complete an Advanced Directive or Living Will.

• Treat staff with respect.

NOTICE OF PRIVACY PRACTICES (HIPAA)

Acknowledgement of Receipt

Effective Date: April 14, 2003

Last Update: February 22, 2022

Please review this disclosure carefully.

The Notice of Privacy Practices tells you how Family Healthcare may use or disclose information about you. Not all situations will be described. Family Healthcare is required to inform you of our privacy practices for the information we collect and keep about you. You may obtain this information by asking anyone at Family Healthcare or by contacting the Privacy Officer at 435-986-2565.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose your medical information. For each category, we explain what we mean and give you some examples; however, we cannot list every possible use or disclosure. If you have questions about the categories or examples, please contact our Privacy Officer at 435-986-2565.

For Treatment: We use your medical information to understand your health condition and to treat you when you are sick. We share your medical information with the doctors, nurses, technicians, health students, and other personnel who are involved in taking care of you. They may work at our offices, at a hospital, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for tests or treatments. For example, a doctor outside our clinic who is treating you for a broken leg will need to know if you have other medical problems because these could impact the ability of your body to heal your broken leg. For example, diabetes may slow the healing process for a broken leg so the other doctor will need to know if you have diabetes. We may also disclose your medical information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We use your medical, behavioral, and dental healthcare information so that the treatment and services you receive from us may be billed to and collected from an insurance company, a state Medicaid agency, or other third party, such as a 340B administrator (prescription medication program).

We may submit (or may already have submitted at a past visit) your personally identifiable information to the Utah Medicaid eligibility database and the Children's Health Insurance Program eligibility database to determine if you are enrolled in or eligible for either program.

For Healthcare Operations: We use your medical/healthcare information to improve the quality of operations at our healthcare practice. For example, we may use your medical records to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine parts of your medical records that do not identify you personally with similar information from other patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, and to compare how we are doing with other healthcare practices.

Optional – Disclosure of Health Information

This release is for the following type of information:

☐ All Records ☐ Prenatal Records ☐ Medication History
☐ Medical Records ☐ Immunizations ☐ Laboratory & Diagnostic Imaging Results
☐ Other (please specify) _____

Record release for the following documents or verbal communication must be initialed by the patient or guardian:

☐ _____ Alcohol/Drug/HIV
☐ _____ HIV/AIDS Diagnosis/Treatment Information
☐ _____ Behavioral Health Treatment Progress/Recommendations/Plans

I hereby authorize Family Healthcare to disclose my medical information, both verbally and written to:

	Name	Telephone Number	Relationship	Specific Limits to Access
1.				
2.				
3.				

I understand the above persons will have to access my medical record until I revoke my consent in writing to Family Healthcare.

_____ **I understand that information released may include medical, mental health, and/or drug and alcohol information.** I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it.

_____ I understand that in order to protect the confidentiality of records, I agree to the release of the necessary information and that my permission is limited to the purposes and persons listed above. I understand that I may withdraw/stop this authorization at any time by written request (except for information already disclosed).

_____ I understand that once this facility discloses my health information per this release, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

_____ I understand that I may withdraw this consent to release information at any time by notifying the agency in writing. I understand that if I do not identify a date or event, then this consent will expire one year from the last date of service to me at Family Healthcare.

I have been given a copy of Family Healthcare's Notice of Privacy Practices and have had a chance to ask questions about how my information should be used.

Signature (Patient/Legal Representative) Date

GOOD FAITH ESTIMATES

Are you uninsured or not using insurance?

If your appointment is 3 or more days away, you qualify for a Good Faith Estimate explaining the expected cost of care.

The Good Faith Estimate is not a bill and shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the appointment was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. There may be additional charges if complications or special circumstances occur.

If after the appointment you receive a bill that is at least $400 more than the "Good Faith Estimate" you received from your provider, you may dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059

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Thank you for choosing Family Healthcare!

Health History Form

American Dental Association
www.ada.org

E-mail: 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: M F

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

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 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?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
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:

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?

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 diet 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 either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) 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 In 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	☐	☐	☐
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	☐	☐	☐
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	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
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:

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:

FOR COMPLETION BY DENTIST

Comments:_____