**Todays Date:**

_____/_____/_____

2904 Mallet Lane
Miles City, MT 59301
Phone: (406) 232-2214
Fax: (406) 232-2031

# Medical and Dental History Record Sheet

**Please Fill Out Completely**

Patient Name_________________________________ If patient is a minor, Parent or Legal Guardian ____________________________

Patient DOB:________________ Age: __________ Sex: Male / Female Patients SSN ______/______/______

Marital Status of Patient: Married / Single / Child / Widowed / Divorced E-mail:__________________________________________

Mailing Address_______________________________________________City______________________________ Zip_______________

Phone: (Home)______________________________ (Cell)______________________________ (Work)____________________________

Patient or Parent's Employer__________________________________ How Long Held_____________ Employment: Full or Part Time

Name of Spouse or Other Parent_______________________________ Spouse or Other Parent's Employer______________________

**If Patient Is Under 18**: Fathers SSN ______/______/______ Mothers SSN ______/______/______

Emergency Contact_________________________ Relationship_________________ Phone Number for Contact_________________

Medical Doctor________________________________ Phone________________________ Date of Last Physical Exam______________

Date of Last Dental Visit___________________ Reason for Today's Visit___________________________________________________

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**Please circle Yes or No** **If answered yes please provide further information**

Are you currently under medical treatment? Y / N _____________________________________________________________________

Do you need an antibiotic pre-med. before dental treatment? Y / N _____________________________________________________

Have you ever been hospitalized for any serious operation or illness? Y / N ________________________________________________

Are you taking any medications, including non prescription? Y / N ____________________________________________________

Please list all medications:_____________________________________________________________________________________

Are you on blood thinners such as Coumadin, Warfarin, Plavix? Y / N ___________________________________________________

Do you use tobacco? Y / N _____________________________________________________________________________________

Do you or have you taken Bisphosphonates for Osteoporosis? Y / N If yes, how long? ______________________________________

Have you ever taken Fen Phen or Redux? Y / N ______________________________________________________________________

**WOMEN ONLY** Are you pregnant? Y / N Nursing? Y / N Taking oral contraceptives? Y / N

Are you interested in whiter or straighter teeth? Y / N

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**How did you hear about our office?**

**Do you have dental implants?**

Y / N

**Do you have allergies to any of the following?**

☐Latex ☐Sulfa Drugs ☐Local Anesthetics ☐Codeine

☐Antibiotics, please specify ___________ ☐Metals ☐Aspirin ☐Other___________

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**Medical- Do you have or have you had any of the following?**

☐Joint replacement
☐Heart disease
☐Heart attack
☐Heart murmur
☐Pacemaker
☐Artificial valve
☐Mitral valve prolapse
☐Chest pains

☐Congenital heart disorder
☐Rheumatic fever
☐Stroke
☐Fainting
☐Breathing problems
☐Emphysema
☐Tuberculosis
☐Stomach problems

☐Cancer
☐Leukemia
☐AIDS/HIV
☐Kidney disease/ dialysis
☐Hepatitis
☐Liver disease
☐Thyroid disease
☐Arthritis
☐Anemia
☐Glaucoma

☐Blood transfusion
☐Hay Fever
☐Psychiatric care
☐Bleeding disorder
☐Radiation treatments
☐Osteoporosis
☐Congestive heart failure
☐Lung disease
☐Sickle cell disease

☐Rheumatoid arthritis
☐Hemophilia
☐Seizures
☐Diabetes
☐Epilepsy
☐Chemo
☐Radiation to head and neck
☐High or low blood pressure

Other conditions not listed ___________________________________________________________

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**Dental- Are you experiencing any of the following?**

☐Pain/ discomfort
☐Sensitivity
☐Lumps or Sores
☐Head/neck/jaw injury

☐TMJ issues
☐History of periodontal disease
☐Dry Mouth
☐Bad Breath

☐Clenching/ grinding
☐Difficulty eating/ chewing
☐Other Concerns__________________

**Name of dental insurance company**________________________________________ **Group #** ___________________________

**Authorization**: I have reviewed the information on this questionnaire and to the best of my knowledge it is complete and accurate. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office and Dr. Yerger of any changes to this information. I authorize the release of any financial or medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I hereby authorize my insurance benefits, to which I am entitled, including private insurance and other healthcare plans to be paid directly to Yerger Family Dental, PC and I am financially responsible for non-covered charges. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another office. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

**Signature of responsible party**__________________________________________________ **Date**: ______________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT

Patient Name: ________________________________________ Guardian Name: __________________________________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.
**Notice of Privacy Practices:** You have the right to read the Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies the Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Compliance Officer: Krissy Yerger, RDH
Telephone: 406-232-2214
Address: 2904 Mallet Ln. Miles City, MT 59301
**Right to revoke:** You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, ______________________________ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.
Signature: ___________________________________________________ Date:____________________________

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal representatives name: _____________________________________________

Relationship to Patient: ___________________________
You are entitled to a copy of this Consent after you sign it

SECTION D: *FOR OFFICE USE ONLY*

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (please specify) ___________________________________

Office Staff Signature: _________________________________ Date: ____________________

# No show, missed appointment office policy form

**Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.**

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept. Missed appointments are very costly to our dental practice. In order to keep patient costs down, we ask that all of our patients make every effort to arrive to their scheduled appointment times. With the exception of emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

**Impact of a "No-Show" Appointment**

-Potentially jeopardizes the health of the "no-showing" patient

-Is unfair (and frustrating) to other patients that would have taken the appointment slot

-Disrespects not only the provider's time, but the time of the entire staff

**Definition of a "No-Show" Appointment**

Yerger Family Dental defines a "No-Show" appointment as any scheduled appointment in which the patient either:

-Does not arrive to the appointment

-Cancels with less than 24 hours' notice

-Arrives more than 10 minutes late and is consequently unable to be seen

**Consequences of a "No-Show" Appointment**

-If you miss 1 appointment you will be reappointed, a warning will be given

-If you miss 2 appointments you may be dismissed from the practice, this is at the discretion of the provider

-If you are dismissed from the practice, all of your future appointments (and possibly family appointments) will be cancelled

-Only emergency treatment will be offered within the first 30 days following dismissal letter

I have read and understood the Yerger Family Dental "No Show" Policy as described above.

Signature: ______________________________ Printed Name:____________________________ Date: ______________