BRANDON GOLDWATER, DMD

MEDICAL AND DENTAL HEALTH HISTORY FORM

Patients Name (first and last): _____ Date of Birth: _____

Home Address: _____ Phone #:_____

Name of previous dentist: _____ Email: _____

Date of Last Exam: _____ Date of last cleaning: _____

Why have you come to see us today? (e.g. pain, checkup, etc)? _____

_____

How did you hear about our practice (please circle): Internet Search Mailer

Google Referred by friend/family/doctor Other_____

Who can we thank for referring you to out practice? _____

Emergency Contact: Name: _____ Phone#: _____

Dental Health

YES	NO	
☐	☐	**Do you brush your teeth? How often?** _____
☐	☐	**Do you floss? How often?** _____
☐	☐	**Are you having and pain or discomfort at this time?**
☐	☐	**Do your gums bleed while brushing and flossing?**
☐	☐	**Are your teeth sensitive to hot or cold liquids/foods?**
☐	☐	**Have you ever experienced any of the following problems with your jaw?**
		Clicking Pain Difficulty in opening and closing Locking Jaw
☐	☐	**Do you have frequent headaches?**
☐	☐	**Do you know if you grind your teeth?**
☐	☐	**Have you ever had any orthodontic treatment?**
☐	☐	**Do you wear dentures or partials? If yes, when were they made?** _____
☐	☐	**Are you pleased with the appearance of your teeth when you smile?**
☐	☐	**Is there any dental treatment you are not happy with? If yes, what?**
		_____
☐	☐	**Are you nervous about dental treatment?**
		*****For Women only**
☐	☐	**Are you pregnant? If yes, what is your due date?** _____
☐	☐	**Are you nursing?**
		Your OBGYN Provider Name _____

Brandon Goldwater, DMD

Medical Health:

Name of Physician: _____ Phone #:_____

Address: _____ Date of Last Visit: _____

YES	NO	
☐	☐	Are you in good health?
☐	☐	Are you under the care of a physician?
☐	☐	Have you been asked by your medical doctor to premedicate before dental treatment?
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Have you been hospitalized in the last 2 years? If yes, why?

_____

Are you allergic or have reacted adversely to any medications? Please list: _____

_____

_____

Check any of the following that you have had or have at the present:

- ☐ **Osteoporosis**
- ☐ **Heart Disease or Heart Attack**
- ☐ **Heart Murmur/Mitral Valve Prolapse**
- ☐ **Rheumatic Fever**
- ☐ **Pacemaker**
- ☐ **Artificial Heart Valve**
- ☐ **Epilepsy or Seizures**
- ☐ **Psychiatric Treatment**
- ☐ **Kidney Disease**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Bleeding Disorders**
- ☐ **Taking Blood Thinners**
- ☐ **Acid Reflux**
- ☐ **Obstructive Sleep Apnea**
- ☐ **Bisphosphonate Therapy**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Thyroid Issues**
- ☐ **Hepatitis A, B, C**
- ☐ **Coronary Artery Disease**
- ☐ **Congenital (Birth Defect) heart lesion.**
- ☐ **Stroke**
- ☐ **History of drug addiction**
- ☐ **Artificial Joints**
- ☐ **AIDS/HIV**
- ☐ **Tuberculosis or Lung Disease**
- ☐ **Sinus Issues**
- ☐ **Liver Disease**
- ☐ **Cancer/Chemotherapy/Radiation**

Please list all medications you are currently taking: _____

_____

_____

Authorization: I have read the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful treatment. If there is any change in my medical status I will inform the dentist.

Signature: _____ **Date:** _____

BRANDON GOLDWATER, DMD

Dental Insurance Information

Primary Insurance Company's Name: _____

Name Of Insured: _____DOB:_____

Id# _____Group# _____

Phone: _____

Street Address: _____

City: _____ State:. _____ Zip Code:_____

Secondary Insurance Company's Name: _____

Name Of Insured: _____ DOB:. _____

Id# _____ Group#_____

Phone: _____

Street Address: _____

City:. _____ State: _____ Zip Code: _____

Email & Text Consent

We are happy to provide patients with the option to participate in our online patient communication system. Some of the features include:

1. Request Appointment via Email
2. Confirm Appointments via Text/Email
3. Receive Text Message Appointment Reminders

Please sign below to indicate that you agree to allow us to use the information in providing your services. You may choose to discontinue your participation in our online communications at any time.

Signature: _____Date: _____

I do not wish to participate in Email and Text Messages.

Signature: _____Date: _____

General Consent for Treatment: HIPAA and Privacy Act

I hereby consent to and authorize Brandon Goldwater, DMD; The Health Insurance Portability and Accountability Act requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. This policy contains information that HIPAA requires us to disclose regarding our privacy practices. We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information except for our disclosures in connection with: defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation. It may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide material to a laboratory, or otherwise make disclosures of your information in connection with providing or coordinating your treatment. Website: https://www.pa.gov/en/agencies/dhs/hipaa-privacy.html

Signature:_____

Consent: Release of Information to Insurance Companies and Third-Party Payers

I hereby authorize and direct Brandon Goldwater, DMD, having treated me, to release to government agencies, Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, insurance carriers, and/or others who are financially liable for my dental care, all information needed to substantiate payment for such care, and to permit representatives thereof to examine and make copies of all records relating to such treatment to the extent necessary to process claims.

Signature:_____

Financial Responsibility/Guarantee of Payment

For, and in consideration of, services rendered by Brandon Goldwater, DMD, I hereby guarantee payment of any bills for such services that or not covered or allowed by the governmental agencies or insurance carriers financially liable for such services.

Signature: _____

No-Show/Cancellation Policy:

Our office will charge a fee of $100.00 to your account for all "no-shows" or cancellations in which the patient does not give our office a 48-hour notice. The office requests that if you are unable to make your scheduled appointment, you call to reschedule your appointment. If it is after or before regular business hours, please leave a message and we will return your call.

Signature: _____