

## IVERSON DENTAL PATIENT INFORMATION

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PO BOX/APT # \_\_\_\_\_

CITY, STATE, ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMPLOYER PHONE# \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SS #\* \_\_\_\_\_ DL#\* \_\_\_\_\_

\*soc sec # and dl # are required if we are filing insurance for you and/or if your account is not paid in full at each appointment

EMPLOYER \_\_\_\_\_ FULL TIME STUDENT?/WHERE \_\_\_\_\_

SEX \_\_\_ MALE \_\_\_ FEMALE      MARITAL STATUS: SINGLE   MARRIED   DIVORCED   SEPERATED   WIDOWED

SPOUSE NAME IF MARRIED \_\_\_\_\_

PHARMACY USED \_\_\_\_\_ PHARMACY PHONE# \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_

**Although Dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.** Circle yes or no, if yes please explain.

Are you under a physician's care now? Yes No If yes, Doctor's name \_\_\_\_\_

Explain treatment \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes No If yes, explain \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes No If yes, explain \_\_\_\_\_

Are you taking any medications, pills, or drugs? Yes No If yes, explain \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, how long? \_\_\_\_\_

Are you on a special diet? Yes No      Do you use tobacco? Yes No      Do you use controlled substances? Yes No

**Women:** Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other \_\_\_\_\_

Do you have, or have you had, any of the following? Circle all that apply.

- |                           |                           |                       |                            |
|---------------------------|---------------------------|-----------------------|----------------------------|
| AIDS/HIV positive         | Cortisone Medicine        | Hemophilia            | Renal Dialysis             |
| Alzheimer's Disease       | Diabetes                  | Hepatitis A           | Rheumatic Fever            |
| Anaphylaxis               | Drug Addiction            | Hepatitis B or C      | Rheumatism                 |
| Anemia                    | Easily Winded             | Herpes                | Scarlet Fever              |
| Angina                    | Emphysema                 | High Blood Pressure   | Shingles                   |
| Arthritis/Gout            | Epilepsy or Seizures      | Hives or Rash         | Sickle Cell Disease        |
| Artificial Hear Valve     | Excessive Bleeding        | Hypoglycemia          | Sinus Troubles             |
| Artificial Joint          | Excessive Thirst          | Irregular Heartbeat   | Spina Bifida               |
| Asthma                    | Fainting Spells/Dizziness | Kidney Problems       | Stomach/Intestinal Disease |
| Blood Disease             | Frequent Cough            | Leukemia              | Stroke                     |
| Blood Transfusion         | Frequent Diarrhea         | Liver Disease         | Swelling of Limbs          |
| Breathing Problem         | Frequent Headaches        | Low Blood Pressure    | Thyroid Disease            |
| Bruise Easily             | Genital Herpes            | Lung Disease          | Tonsillitis                |
| Cancer                    | Glaucoma                  | Mitral Valve Prolapse | Tuberculosis               |
| Chemotherapy              | Hay Fever                 | Pain in Jaw Joints    | Tumors or Growths          |
| Chest Pains               | Heart Attack/Failure      | Parathyroid Disease   | Ulcers                     |
| Cold Sores                | Heart Murmur              | Psychiatric Care      | Venereal Disease           |
| Congenital Heart Disorder | Hear Pace Maker           | Radiation Treatments  | Yellow Jaundice            |
| Convulsions               | Heart Trouble/Disease     | Recent Weight Loss    |                            |

**HAVE YOU EVER BEEN TOLD YOU NEED TO PRE-MEDICATE (take anti-biotics) BEFORE A DENTAL APPOINTMENT?  YES  NO**

Have you ever had any serious illness not listed above? Yes No If yes, explain \_\_\_\_\_

**PLEASE CONTINUE BELOW**

Patient name \_\_\_\_\_

MEDICAL HISTORY QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I certify that the answers to the health questions on the other side of this page are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, **I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.**

I authorize Dr. Iverson, Dr. Larsen and/or such associates or assistants as may be designated to perform those 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 agents(s), including those related to restorative, palliative, therapeutic or surgical treatments.

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

I understand that as part of the 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 and 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 inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill componets, etc. may be aspirated 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 disclose to the dentist 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 may 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient, legal guardian or authorized agent of patient)

RESPONSIBLE PARTY/ACCOUNT INFORMATION

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ PO BOX/APT # \_\_\_\_\_

CITY, STATE, ZIPCODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SOC SEC #\* \_\_\_\_\_ DL#\* \_\_\_\_\_

soc sec # and dl # are required if we are filing insurance for you and/or if your account is not paid in full at each appointment

I understand that I am responsible for all costs of dental treatment for all persons placed on my account. The balance for dental services is due the day of the appointment unless other arrangements are made. I understand that a fee of \$20 per half hour scheduled may be charged for any appointment broken without 24 hours notice. **I understand that a 1.75% monthly (21% APR) finance charge (\$2 minimum) may be charged on all account balances over 60 days past due. I agree to pay cost and attorney's fees if any delinquent balance is placed with an agency or attorney for collection of suit (up to 50% of the balance that is turned over).**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient, legal guardian or authorized agent of patient)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I acknowledge that I have received or have been offered a copy of the Iverson Dental notice of privacy practices. The information that may be disclosed is outlined in the privacy act notice. If I am listed on an account other than my own (spouse, parents, legal guardian) and/or am covered by an insurance policy in any other name but my own, I authorize release of this information to the account holder and/or insurance policy holder. Also, information may be disclosed to a spouse, parent, and/or adult child of my designation.

Spouse's name \_\_\_\_\_

Parent's name/s \_\_\_\_\_

Adult child's \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient, legal guardian or authorized agent of patient)