Patient Information

First Name	Middle	Last Name

Gender	Date of Birth

Address	City	State	Zip Code

Contact Information

Phone (cell)	Phone (home)

Email address (required)

Emergency Contact Information

Name of Local Contact	Phone number	Relationship to Patient

Parent or Guardian

First Name	Last Name	Birthdate

Relationship to Patient

Medical History

Your health status, as well as medications, can impact your oral health. We thank you for your careful consideration as you complete this section.

Are you currently under a physician's care? Y N

Please provide the name of your primary care physician, if you have one:

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Doctor's Name **Practice Location** **Approximate date of last exam**

Please indicate all medications you are currently taking (including over-the-counter and herbal remedies), with dosages, if you know them:

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Do you use any form of tobacco? Y N

If YES, what kind, how much, and how often? ______________________________

Are you allergic to any of the following?

Aspirin Penicillin Codeine

Acrylic Metal Latex

Other (please indicate): ______________________________

Have you ever been told you need to take antibiotics before dental appointments?

Y N

Do you currently, or have you had any of the following medical conditions?

- Artificial joint Y N

Please describe device, including date of insertion: ______________________________

- Angina / Chest Pain Y N
- Artificial heart valve Y N
- Heart Disease Y N
- Congenital Heart Disease/Disorder Y N

If yes, please describe: ______________________________

- Pacemaker / other implanted cardiac device Y N

Please describe device, including date of insertion: ______________________________

- Heart Murmur Y N
- Tuberculosis Y N

- Asthma Y N
- Emphysema Y N
- COPD Y N
- Frequent Cough Y N
- Hay Fever/Allergies Y N
- Diabetes Y N Type I Type II Pre-Diabetic
- Kidney Problems Y N
- Liver Disease Y N
- Cancer (including blood cancers) Y N

Please describe:____

- Chemotherapy Y N
- Radiation therapy to head and neck Y N
- Thyroid Disease Y N

Please describe: ____

- HIV/AIDS Y N
- Hepatitis Y N A B C
- Blood Disease/Disorder Y N

Please describe:____

- Stroke Y N
- Autoimmune Disease Y N

Please describe: ____

Women:

Are you pregnant or suspect you may be pregnant? Y N

Are you nursing? Y N

Is there anything else you would like us to know about your medical history? Please describe.

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Consent: By signing this form I hereby consent to, authorize and request the performance of dental services for myself or dependent, and give my consent to any advisable and necessary dental procedures to be administered by the dental hygienist and/or dental assistant. I authorize and understand that an affiliate dentist will review my records including but not limited to x-rays, photos and dental charting electronically and inform me of any further dental treatment that is required. I understand that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist. I understand that if desired I may obtain an in person examination by an affiliate dentist at an affiliate practice location by appointment. I understand that I am financially responsible for the services provided.

Notice of Privacy Practices: By signing this form I hereby consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses 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 of Privacy Practices accompanies this 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 that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting MyLife Dental, 1380 Duckwood Dr, Suite 108, Eagan, MN 55123. Telephone: 651-315-7668. You have the right to revoke this consent at any time by giving your written notice of your revocation submitted to the contact information for Mylife Dental 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, and that we may decline to treat you or to continue treating you if you revoke this consent.

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Patient Signature (or Parent/Guardian) Today’s Date