E. Tom Mims, D.M.D.

96 Central Street, Murphy, NC 28906 | Phone: (828) 837-3577 | www.mimsfamilydentistry.com

HEALTH HISTORY

So that we may best provide for your safety, please complete the following medical information.

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Date of birth _____ Age _____
Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you been hospitalized or had a serious illness or operation in the past 5 years?	☐	☐
If yes, explain _____		
4. (Women) Are you nursing or pregnant? If pregnant, give due date.	☐	☐
5. Do you use tobacco in any form? If yes, how much?	☐	☐
6. Do you use alcoholic beverages?	☐	☐
7. Are you on a diet? If yes, what type?	☐	☐
8. Have you had or do you currently have:		

	YES	NO
GENERAL		
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats or persistent fever	☐	☐
EYES		
Contact lenses	☐	☐
Glaucoma/eye disease	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment/mental health problems	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever/sinus problems	☐	☐
Persistent cough/cough producing blood	☐	☐
Sputum production (phlegm)	☐	☐
Difficultly breathing while lying down	☐	☐
Other _____		
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Low blood sugar	☐	☐
Other _____		

	YES	NO
HEART/BLOOD VESSELS		
Irregular heartbeat	☐	☐
Rheumatic fever or mitral valve prolapse	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort/angina	☐	☐
Heart attack/trouble or heart surgery	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve or pacemaker	☐	☐
Other _____		
BONE/MUSCLES		
Fibromyalgia	☐	☐
Arthritis/rheumatism	☐	☐
Artificial joints	☐	☐
DIGESTIVE SYSTEM		
Hepatitis/jaundice	☐	☐
Stomach hyperacidity	☐	☐
Stomach ulcers, GERD, or reflux.	☐	☐
Other _____		
URINARY		
Kidney disease/problems	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
Bleeding tendency	☐	☐
OTHER		
Radiation therapy/chemotherapy	☐	☐
Tumors, growths/cancer	☐	☐
Chronic fatigue syndrome	☐	☐
HIV positive	☐	☐
Chemical or alcohol dependency	☐	☐
Recurring infections of any kind	☐	☐

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9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics (novocaine, etc.)	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐
Penicillin/other antibiotics	☐	☐
Aspirin/Ibuprofen	☐	☐
Codeine or other narcotics	☐	☐
Iodine	☐	☐
Latex/rubber products	☐	☐

Other allergies _____

10. Are you taking any the following?

	YES	NO
Antibiotics/sulfa drugs	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medication	☐	☐
Cortisone/steroids	☐	☐
Antihistamines/allergy drugs/cold remedies	☐	☐
Tranquilizers (Valium, etc.)	☐	☐
Insulin/other diabetes drugs	☐	☐
Digitalis/other heart medications	☐	☐
Nitroglycerin	☐	☐
Asprin/Advil	☐	☐
Natural herbal supplements/homeopathic remedies	☐	☐
Birth control pills	☐	☐
Tagamet	☐	☐

Other medication _____

If yes to any of the above, list name of medication and dosage below:

1. _____
2. _____
3. _____
4. _____

11. Please list any weight loss medications you have taken or are currently taking (including FenPhen, Redux and herbal supplements).

_____

12. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

_____

13. Physician's Name _____ Phone: _____
14. Have you ever had any serious trouble associated with previous dental treatment? _____

_____

15. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes ☐ NO ☐
16. Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐
17. Date of last dental visit _____ Date of last teeth cleaning _____
18. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
    If so, when? _____
19. Do you have or have you ever had any of the following?

MOUTH	YES	NO
Bleeding or sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue/lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling/lumps in mouth	☐	☐
Orthodontic treatments (braces)	☐	☐
Biting cheeks/lips	☐	☐
Clicking/popping jaw or TMJ problems	☐	☐
Difficulty opening or closing jaw	☐	☐
Removable dental appliance	☐	☐

TEETH	YES	NO
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food trapping between teeth	☐	☐
Clenching/grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐

Other _____

How often do you brush? _____ Floss? _____

Brush is: Soft ☐ Medium ☐ Hard ☐ Electric ☐

Is there any condition concerning your health the doctor should be told? YES ☐ NO ☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.

Our entire staff is dedicated to your care. Please inform us over the years of any change in your health or any medications you may be taking. These changes need to be discussed before having any dental treatment performed. All our staff persons fully respect your confidentiality.

Signature of Patient, Parent, or Guardian _____ Date _____

Doctor's Signature _____ Date _____

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Name: _____ Social Security No.: _____

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____

Birthdate: _____ Age: _____ Email Address: _____

Home Phone No.: _____ Work Phone No: _____ Cell Phone No.: _____

Patient or Parent's Employer: _____ Occupation: _____

Employer's Address: _____

Names of Other Dependants: _____

Spouse's Address, if Divorced or Separated: _____

Name of Closest Relative Not Living With You: _____

Address: _____ Phone No.: _____

In Case of Emergency, Please Notify: _____

Person Responsible for Account: _____

Address: _____ Phone No.: _____

Whom May We Thank For Referring You: _____

If You Have Dental Insurance, Please Advise.

Company Name and Address: _____

Group No.: _____ Subscribe No.: _____

Subscriber's Name: _____ Date Of Birth: _____

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CONSENT FOR USE AND DISCLOSURE OF
HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient# _____ Social Security #: _____

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 operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of 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 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 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 of our Notice, at any time by contacting:

Contact Person: Debbie Keys Telephone: 828-837-3577
96 Central St.
Murphy, NC 28906

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us 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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION AND/OR PAYMENT ACTIVITIES TO SOMEONE OTHER THAN THE PATIENT: Occasionally there are times when it becomes necessary to discuss treatment and /or payment activities with someone other than the patient. An example of this would be a spouse, child or other family member or friend of the patient. My signature on the following line indicates my consent for this disclosure of health information and/or payment activities and names the person or persons I am consenting this information be discussed with or given to.

_____
Signature

Person or Persons to Whom I am Authorizing My Health Information and/or Payment Activities to be Disclosed to or Discussed with.

SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this Consent from your 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 healthcare operations.

SIGNATURE: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____
Relationship to Patient: _____

Print Form