RAPHA DENTAL
Gentle & Affordable Dentistry

Medical History Form

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor: _____ Phone: _____
Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Local Anesthetics	☐	☐	Metals
☐	☐	Aspirin	☐	☐	Hay fever / Seasonal
☐	☐	Penicillin or other Antibiotics	☐	☐	Latex (rubber)
☐	☐	Codeine or other Narcotics	☐	☐	Iodine
☐	☐	Sulfa	☐	☐	Food
☐	☐	Barbiturates, Sedatives, or Sleeping Pills	☐	☐	Other

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	History of Heart Problems	☐	☐	Arthritis
☐	☐	Bleeding Problems	☐	☐	Autoimmune disease
☐	☐	Replaced / Damaged Heart Valves	☐	☐	Lung Problem (Asthma, Bronchitis and etc)
☐	☐	Pacemaker	☐	☐	Psychiatric Treatment
☐	☐	High or Low Blood Pressure	☐	☐	Kidney Disease
☐	☐	Anemia	☐	☐	Stroke
☐	☐	AIDS/HIV	☐	☐	GI Problem / GERD / Ulcer
☐	☐	Sexually Transmitted Disease	☐	☐	Diabetes
☐	☐	Osteoporosis	☐	☐	Seizure / Epilepsy
☐	☐	Thyroid Disease	☐	☐	Neurological Disorder
☐	☐	Sleep Disorder / Snore	☐	☐	Chronic Pain or Headache
☐	☐	Vertigo	☐	☐	Cancer / Chemo / Radiation Therapy

Other Medical Conditions _____

Do you use controlled substances (Drug)? _____

Tobacco use? If so, what kind and how much? _____

Do you need to take Prophylactic Antibiotic for Dental Procedure? (Y/N) _____

Are you taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for Osteoporosis or Paget's disease? (Y/N) _____

WOMEN ONLY: Are you Pregnant? (Y/N) _____

Signature :

_____

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PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: _____

Email: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Are you afraid of coming to the dentist? (Y/N) If yes how afraid from 1 ~ 10? _____

How did you hear about us?

_____

Online Search, Word of Mouth, Insurance, Post Card, Building Sign, Other

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Subscriber Birthdate: _____

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

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AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

If I have dental insurance, I assign it/them directly to Rapha Dental all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above name dental office may use my health information and may disclose such information to the Dental Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Name of Signature of Patient or Guardian and Date **Signature**

Office Policy regarding Appointment Change or Cancellation Notice Requirements

Please understand that at Rapha Dental, your dental appointment reserves valuable professional time, not only our doctor but with our entire staff. Your appointment time is reserved exclusively for you so that we can provide you with our undivided attention.

We respect the value of your time and kindly request that you respect and value our time as well. Because of the individual nature of each appointment, a 48 hour notice is required for any cancellation or changes that may be required to your appointed time.

My signature below indicates that I understand the value of this appointment and I am willing to accept these requirements. I also understand that I will be responsible for $89 charge if such notice is not given.

_____

Signature Date

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Informed Consent for Dental Treatment

If you have any questions, please ask your doctor prior to initialing

1. Preliminary Consent for Treatment

I understand I may have any or all of the following done today: Exam, Radiographs “X-rays” and cleaning “Prophylaxis”
.

2. Medications, Substances, Local Anesthesia, and Medical Conditions

I understand that antibiotics, analgesics, “Pain medicines”, anesthetics, latex and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting and/or more severe allergic reactions. I have informed the dentist of any known allergies and/or medical conditions, including possible pregnancy

3.Changes to Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found during treatment that were not evident during the initial examination. Some of these changes are, but are not limited to, root canal therapy that is necessary following the placement of “deep fillings” or Crowns recommended after placement of “large fillings”. I authorize my dentist to make any changes and/or additions to my treatment plan as necessary

4.Dental Benefits

I understand that treatment that my dentist recommends is based on what he/she determines is best for my dental health, and not necessarily based on what an insurance plan will pay. Therefore I understand that my insurance (if any) may not cover all aspects of my treatment plan and I will be financially responsible for any treatment not covered by the insurance plan. I understand the treatment plan proposed to me is an estimate of insurance benefits and my actual coverage may differ due to frequency limitations, group coverage, incomplete information provided by my insurance company, etc. I also acknowledge that I am responsible for any balance remaining in the event that my insurance coverage is terminated for any reason. In the event the account goes to collections, patient will be responsible for a minimum $20 collection fee.

I understand dental treatment has potential risks and consequences. Likewise, so does the refusal or denial of dental treatment. Untreated conditions may lead to pain, swelling, infection, tooth loss and/or other severe consequences. I understand that dentistry is not an exact science and that no exact results can be assured or guaranteed. I have had the opportunity to have all of my questions answered by my dentist.

Signature of Patient / Guardian	Name of Patient / Guardian, Relationship to Patient and Date