

DENTAL HISTORY

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever had prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had instruction on the correct method of brushing your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you ever had instructions on the care of gums?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you suffer anxiety or gagging during dental procedures?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	18. How important are your teeth to you? _____		
7. Have you ever experienced any of the following problems in your jaw?			_____		
a) Clicking	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you want to avoid dentures? Why? _____		
a) Pain (joint, ear, side of face?)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
a) Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	20. Are you unhappy with the appearance of your teeth? _____		
a) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	Why? _____		
8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. What changes would you make? _____		
9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>	22. Interest and hobbies? _____		
11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you had any periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICATIONS

List medications you are currently taking:

Med. Dr. Name _____

Phone # _____

Pharmacy Name _____

Phone _____

ALLERGIES

Are you allergic to or have you had any reactions to following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (eg. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Pencillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY:

	YES	NO
A) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
B) If you are pregnant, when is the due date? _____	<input type="checkbox"/>	<input type="checkbox"/>
C) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
D) Are you taking birth control pills/ hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: A change in my healthy status must be reported to the office at the time of my visit. To the best of my knowledge, the foregoing questions have been accurately answered.

INFORMED CONSENT

I understand that at any time during the course of treatment it may be necessary to change or add procedures because of conditions found that either were not discovered or discoverable during the initial examination or are conditions that developed subsequent to that date. I authorize these changes and additions to my Treatment Plan as necessary. I acknowledge there will be a charge for each broken appointment if 24 hours advance notice is not given. A \$100 fee will be charged for any scheduled appointment exceeding one hour, without 24 hours notice if unspecified by my insurance or dental plan.

Patient Signature

Date

Print name of person signing for the patient and their relationship to the patient

Date

PATIENT NUMBER

JAMES KERNS, D.M.D., PLLC
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**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE
OPERATIONS**

I consent to the use of disclosure of my health information for the purpose of diagnosing providing treatment to me, obtaining payment for my health care bills or to conduct health. I understand that diagnosis or treatment of me maybe conditioned upon my consent by my signature on this document.

I understand I have the right to request a restriction as to my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is not required to agree to the restriction that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, expecting that the above organization has take action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the above organization Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the above organization. The Notice of Privacy Practices is also provided at the above organization and on the website if applicable. This Notice of Privacy Practices also describes my rights and the above named organization’s duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative’s Authority