Belknap Dental Associate's
Medical Update

For BDA only:
Patient Acct # _____

Patient Name: _____ Date of Birth: _____ Date:_____

Medical Update Questionaire	Y	N	If yes, please explain
Are you having pain or discomfort at this time?			
Have you been hospitalized or had a major operation during the past year?			
Have you been under the care of a medical doctor during the past year?			
Are you currently being treated by a physician? If so, physician's name and reason			
Have you taken or changed any medication or drugs during the past year?			
Are you now taking any medication or supplements? If yes, please list name and what it is for **Note: If 3 or more daily prescriptions, please provide Belknap with an updated list each visit**			
Do you take, or have you taken, Phen-Fen or Redux?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Do you use any form of tobacco, cannabis and/or vaping? If so, how often?			
Do you have any artificial joints? (hip, knee, etc)			
Are you taking any blood thinners?			
Do you have trouble with sleep apnea (trouble sleeping) or snoring?			

Women: Are you? **(please check)**

☐	Pregnant/Trying to get pregnant	☐	Nursing	☐	Taking oral contraceptives

Are you allergic to any of the following? **(please check if you are allergic)**

☐	**Penicillin**	☐	Codeine	☐	**Latex**	☐	**Erythromycin**	☐	Food Allergies:
☐	Aspirin	☐	Local Anesthetics	☐	Sulfa Drugs	☐	Salfite	☐	Nickel

	Y	**N**	
Any other allergies not listed?			
Do you use controlled substances?			

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

	Y	N		Y	N
Any Heart Issues			Heart Pacemaker		
Angina Pectoris			Mitral Valve Prolapse		
Heart Disease or Attack			Stroke		
Heart Valve Defect			**Artificial Heart Valve**		
Congenital Heart Disease			Arteriosclerosis		
Heart Murmur			**Bacterial Endocarditis**		
Heart Surgery/By-Pass			High Blood Pressure		
Heart failure			Low Blood Pressure		

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

	Y	N		Y	N
Arthritis			Epilepsy or Seizures		
Diabetes			Ulcers/Stomach Problems		
Kidney Trouble			**Rheumatic Fever**		
Thyroid Problems			Cold Sores/Fever Blisters		
Adrenal/Pituitary Problems			Difficulty Healing		
Glaucoma					

Have you been treated or have you received any of the following?

	Y	N		Y	N
Radiation Therapy			Liver Disease		
Chemotherapy			**Hepatitis**: (please circle)		
Cancer/Tumor/Other			A B C D E		

Do you have, or have you had, any of the following bleeding issues?

	Y	N		Y	N
Hemophilia			Sickle Cell Disease		
Anemia			Bruise Easily		
Blood Transfusion			Any Bleeding Disorders		

Do you have, or have you had, any of the following breathing issues?

	Y	N		Y	N
Lung / Breathing Problems			Chronic Cough		
Emphysema			Sinus Trouble		
Bronchitis			Asthma		
Tuberculosis			Fainting or Dizzy Spells		

Are you or have you been treated for the following?

	Y	N		Y	N
Venereal Disease			Drug Addiction		
A.I.D.S			Alcoholism		
Sexually Transmitted Diseases			Nervousness / Mental Disorder		
H.I.V. Positive			Psychiatric Treatment		
Other Infectious Diseases			Developmentally Disabled		

Do you have or have you had any disease, condition, or problem not listed above? If yes, please list

Do you need to take antibiotic pre-medications prior to dental appointments? If so, name of antibiotic

Patient Insurance Consent

- I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
- I authorize the Dentist (s) or designated staff treating me to perform diagnostic procedures deemed appropriate to make a thorough diagnosis of my oral health. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures including administering medications as prescribed by the Dentist (s) and mutually agreed upon by me.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 30 days from the date of treatment will be assessed a late charge per month and if payment is not received within 90 days, I agree to pay any additional charges associated with collections.

Signature of Patient or
Parent/Guardian if Patient is a minor _____ Date _____

Signature of Doctor _____ Date _____

Please read next page and sign

Patient Name (please print)_____ Date _____

Has your insurance changed: No ☐ Yes ☐ If yes, please fill out following information:

PRIMARY DENTAL INSURANCE COVERAGE Policy Holder's Name _____

Policy Holder's DOB ____/_____/_____ Relation: _____

Employer Name _____

Employer Address _____

Dental Insurance Company _____ Phone # _____

Insurance Address _____

Person(s) covered by this insurance: _____

_____

Policy Holder's SS # _____

Policy Holder's ID# _____

Policy # _____

Group # _____

SECONDARY DENTAL INSURANCE COVERAGE Policy Holder's Name _____

Policy Holder's DOB ____/_____/_____ Relation: _____

Employer Name _____

Employer Address _____

Dental Insurance Company _____ Phone # _____

Insurance Address _____

Person(s) covered by this insurance: _____

_____

Policy Holder's SS # _____

Policy Holder's ID# _____

Policy # _____

Group # _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (Guidelines effective August 2013)

Name: _____ **Date of Birth:** _____

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 is posted in hallway or you can request a copy from the receptionist. 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.

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.

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of the Consent form and Belknap Dental's 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 heath care operations.

Signature of Patient or
Parent/Guardian if Patient is a minor _____ Date: _____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature of Patient or
Parent/Guardian if Patient is a minor _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.