For BDA only:
Patient Acct # ____________________

Belknap Dental Associate's
Medical Update

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		Sulfite		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) A B C D E		
Cancer/Tumor/Other					

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 antibiotic below

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: ____

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Policy Holder's SS # ___________________________

Policy Holder's ID# ___________________________

Policy # ___________________________

Group # ___________________________

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

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

I acknowledge that I have been offered a copy of Belknap Dental Associates' Notice of Privacy Practices, which has an effective date of 9/23/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practice at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices if requested:

____ ___________________________

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

____

Print Name

____

Relationship to Patient (if not signed by patient)

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 specialist and dentist. I give my permission for this service.

Patient or Parent/Guardian if Patient is a minor ____ **Date** ______________

TEXTING CONSENT

Please check the box below to give your consent and opt in to receive text messages from Belknap Dental Associates. By opting in, you agree to receive appointment reminders, important updates, and feedback requests via text message. Standard messaging rates may apply.

I consent and opt in to receive text messages from Belknap Dental Associates.

***You can opt out at any time by replying 'STOP' to any message.**

Patient or Parent/Guardian if Patient is a minor ____ **Date** ______________

Please note that messaging is not a secure form of communication, and we recommend discussing any sensitive or personal information during your office visits.