NORTHEAST MISSOURI HEALTH COUNCIL

Partners for a Lifetime of health

Date:_____

Patient Name: DOB: Gender:

Address: Phone: Work phone:

MEDICAL HISTORY

Name of Physician: Phone:

When was your last physical?

Are your immunizations up to date? yes / no

Are you now under the care of a physician? yes / no

If yes, for what reason?

Are you presently taking any medications/drugs/pills? yes / no

Please list:

Have you ever had to be **pre-medicated** before dental treatment? yes / no

Have you ever or are you currently taking any **blood thinner** medications? yes / no

(ie. Plavix, Xarelto, Eliquis, Pradaxa, Coumadin, Warfarin)

Have you ever or are you currently taking any medication for:

osteoporosis, cancer or rheumatoid arthritis? yes / no

Have you ever or are you currently taking an **oral or IV Bisphosphonate or any of the following medications? (ie. Actonel, Boniva, Fosamax, Didronel, Prolia, Zometa)** yes / no

Are you **allergic** (or have an adverse reaction) to? **(circle all that apply below)**

Penicillin Other Antibiotic **Local Anesthetic** **Epinephrine** Aspirin None

Codeine **Latex** Other Please describe:

Are you sensitive or allergic to latex? yes / no

(i.e. Experienced itching, rash or wheezing after using latex gloves or handling a balloon)

Do you have, or have you had any of the following: (Check boxes that apply.)

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Artificial Joint
- ☐ Anorexia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Blood Clotting disorder
- ☐ Blood Transfusion
- ☐ Bulemia
- ☐ Cancer
- ☐ Chemo/Radiation Therapy
- ☐ Cognitive Disability
- ☐ Congenital Heart Defect
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Food Allergies
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain Management
- ☐ Recurring Otitis/Ear Infect.
- ☐ Recurring Strep
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Shingles
- ☐ Vision Impairment/Problems
- ☐ Wheezing
- ☐ Family Hx of Von Willebrand
- ☐ Hearing Impaired
- ☐ MRSA
- ☐ Neurological Disorders
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ STD/STIs
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Surgical History:

Have you had any of the following surgeries listed below? **(circle all that apply below)**

Adenoidectomy Ear tubes Fundoplication Gastrostomy tube
Heart Surgery Joint Replacement Organ Transplant Prosthetics/Rods/Pins
Removal of Spleen Tonsilectomy VP Shunt

Have you had any of the other surgeries, hospitalizations or illness not listed above?

If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? yes / no

If yes, please explain: _____

Do you currently smoke or use the following tobacco products? yes / no

Cigarettes Cigars Pipe Chew Vaping/E-Cigarettes

Have you used tobacco products in the past? yes / no

If yes, how long ago? _____

Do you drink alcoholic beverages? yes / no

If yes, how much? _____

WOMEN: Are you pregnant? yes / no

Are you nursing? yes / no

Do you take birth control medications? yes / no

Do you anticipate becoming pregnant? yes / no

DENTAL HISTORY

Date of Last Dental Visit: _____ OR UNKNOWN

Have you experienced/Are you experiencing any of the following? **(Check all that apply.)**

- ☐ Bleeding Gums
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets/sour
- ☐ Pain w/teeth
- ☐ Sores in/around mouth
- ☐ Head/neck/jaw injury
- ☐ Frequent headaches
- ☐ Clench/grind teeth
- ☐ Bite lips/cheeks frequently
- ☐ Clicking in jaw
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing mouth
- ☐ Difficulty in chewing
- ☐ Orthodontic work
- ☐ Prolonged bleeding following extraction

Have you ever had instruction on the correct method of brushing your teeth? yes / no

Have you ever had instructions on the care of your gums? yes / no

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CONSENT TO TREAT/ACOMPANY MINOR

(For patients under the age of 18 years)

DATE: ____/____/____

Child's name:_____DOB ____/____/____

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council (to include NE Family & Behavioral Health, Ob/Gyn Specialty Group, NE Pediatrics, NE Dental, Kahoka Dental, Edina Family Health, NE Family Health in Milan, Macon Family Health, and Macon Dental.)

Additionally, I authorize the following individual(s) to bring the above-named child to this clinic, besides myself: (please print names)

_____/_____
(relationship)

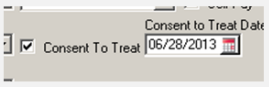
_____/_____
(relationship)

_____/_____
(relationship)

Parent/guardian signature:_____

For staff use only:

Staff/witness initials:_____
Staff instructions: sign, scan, check-mark CTT box, and date in UDS tab on patient check-in→



To be updated every 6 months until age 18!

Administration & Business Office 1416 Crown Drive
Kirksville, Missouri 63501
Phone (660) 627-5757 Fax (660) 627-5802

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Patient Name_____dob_____/_____/_____
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: **treatment, payment, and healthcare operations.** I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Northeast Missouri Health Council, Inc. (NMHC, Inc.), has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time to receive a current copy.

Patient/Guardian Signature_____ Date_____/_____/_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

Assignment of insurance benefits, release of information, and authorization of treatment. I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original. ***(If uninsured, this signature is not required.)***

Patient/Guardian Signature_____ Date_____/_____/_____

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