



# Welcome to our Practice!

Will you please help by providing us with the following confidential information?

**Dr. Brett Farnham**

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## DENTAL HEALTH HISTORY

Patient Name: \_\_\_\_\_

### Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Bleeding, swollen or irritated gums
- Bad breath or bad taste in your mouth
- Tooth pain or discomfort when chewing
- Jaw joint pain
- Grinding or clenching teeth
- Loose, tipped or shifting teeth

### Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Do you smoke or use chewing tobacco? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

If you could whiten your teeth for a cost anyone could afford, would you do it? \_\_\_\_\_

### If you could change your smile, you would:

- Make them brighter
- Repair chipped teeth
- Have a smile makeover
- Make them straighter
- Replace missing teeth
- Close Spaces
- Replace black metal fillings with natural, tooth-colored fillings
- Replace old crowns that don't match

### On a scale of 1 – 10, with 10 the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where would you rate your smile currently? 1 2 3 4 5 6 7 8 9 10

Where would you want your smile to be? 1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?  
\_\_\_\_\_

### Please share the following dates:

Your last cleaning \_\_\_ / \_\_\_ Your last oral cancer screening \_\_\_ / \_\_\_

Your last complete X-Rays \_\_\_ / \_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

Name of Previous Dentist(optional): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

What is the most important thing to you about your dental visit today?  
\_\_\_\_\_

### Please check the following which are important to you when making your dental health decisions.

- Convenience
- Finances
- What insurance covers
- Appearance
- Time
- Health
- Relationship with Dental Team
- Quality of care
- Detailed treatment explanations
- Technology
- Comfort
- Fear or Anxiety



**MEDICAL HEALTH HISTORY**

**PATIENT NAME:** \_\_\_\_\_

**A. CIRCLE YOUR ANSWERS** (leave BLANK if you do not understand the question):

- 1. Yes No Are you in good health?
- 2. Yes No Has there been a change in your health within the last year? Explain: \_\_\_\_\_
- 3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: \_\_\_\_\_

4. Yes No Are you being treated by a physician now? For what? \_\_\_\_\_

Name of your physician: \_\_\_\_\_ Date of last Medical Exam: \_\_\_\_\_

**B. HAVE YOU EVER EXPERIENCED OR HAVE YOU HAD:**

- |   |                                       |
|---|---------------------------------------|
| 5. Yes No Chest Pains   | 28. Yes No Dizziness                  |
| 6. Yes No Swollen Ankles                                      | 29. Yes No Ringing in ears            |
| 7. Yes No Shortness of breath                                 | 30. Yes No Frequent Headaches         |
| 8. Yes No Recent weight loss, fever, night sweats             | 31. Yes No Fainting spells            |
| 9. Yes No Persistent cough, coughing up blood                 | 32. Yes No Blurred Vision             |
| 10. Yes No Bleeding problems, bruising easily                 | 33. Yes No Seizures                   |
| 11. Yes No Sinus Problems                                     | 34. Yes No Excessive thirst           |
| 12. Yes No Difficulty swallowing                              | 35. Yes No Frequent urination         |
| 13. Yes No Diarrhea, constipation, blood in stools            | 36. Yes No Dry Mouth                  |
| 14. Yes No Frequent vomiting, nausea                          | 37. Yes No Jaundice                   |
| 15. Yes No Difficulty urinating, blood in urine               | 38. Yes No Joint pain, stiffness      |
| 16. Yes No Sleep apnea or chronic snoring                     | 39. Yes No Herpes                     |
| 17. Yes No Heart disease                                      | 40. Yes No HIV positive or AIDS-ARC   |
| 18. Yes No Heart attack, heart defects                        | 41. Yes No Tumors, Cancer             |
| 19. Yes No Heart murmur                                       | 42. Yes No Arthritis, rheumatism      |
| 20. Yes No Rheumatic fever                                    | 43. Yes No Eye disease                |
| 21. Yes No Stroke, hardening of arteries                      | 44. Yes No Skin disease               |
| 22. Yes No High Blood Pressure                                | 45. Yes No Anemia                     |
| 23. Yes No TB, emphysema or other lung diseases               | 46. Yes No VD (syphilis or gonorrhea) |
| 24. Yes No Hepatitis, A B C                                   | 47. Yes No Kidney, bladder diseases   |
| 25. Yes No Stomach problems, ulcers                           | 48. Yes No Thyroid, adrenal diseases  |
| 26. Yes No Diabetes   | 49. Yes No Latex allergy              |
| 27. Yes No Family History of diabetes, heart problems, cancer |                                       |

**List any other allergies:**  
(drugs, food, medications, metals, jewelry, acrylics)

**C. DO YOU HAVE OR HAVE YOU HAD:**

- |                                     |   |
|-------------------------------------|---|
| 50. Yes No Surgeries _____          | 55. Yes No Radiation Treatments _____                       |
| 51. Yes No Blood Transfusions _____ | 56. Yes No Chemotherapy _____                               |
| 52. Yes No Artificial Joint _____   | 57. Yes No Prosthetic heart valve _____                     |
| 53. Yes No Contact Lenses _____     | 58. Yes No Pacemaker _____                                  |
| 54. Yes No Psychiatric Care _____   | 59. Yes No <b>Women only:</b> Birth Control Pills           |
|                                     | 60. Yes No <b>Women only:</b> Currently Pregnant or nursing |

**D. DO YOU TAKE OR HAVE TAKEN:**

- 61. Yes No Recreational drugs
- 62. Yes No Alcohol
- 63. Yes No Tobacco in any forms
- 64. Yes No Phen Phen diet Pills or any other diet pills
- 65. Yes No Bisphosphonates: Medications for Osteoporosis

**LIST MEDICATIONS & VITAMINS:** \_\_\_\_\_

**E. ALL PATIENTS:**

66. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:  
\_\_\_\_\_

67. Yes No Have you ever been told by a physician or dentist that you need to be pre-medicated prior to any dental treatment?  
\_\_\_\_\_

# PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Preferred to be called: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M   F

Mailing Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

SS#: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address, City State, Zip \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone # : \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Address (if different than above): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address, City, State, Zip: \_\_\_\_\_

In the event that we must **contact you for scheduling changes**, etc, please indicate the **best PHONE NUMBER during business hours** to phone you:

Phone number: \_\_\_\_\_ Place \_\_\_\_\_ Time: \_\_\_\_\_

How did you hear about our office? Please check:

Internet Search  Patient referral  Website  Radio Ad  Yellow Pages  Other \_\_\_\_\_

# INSURANCE INFORMATION:

Primary Insurance Company : \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_

Group# or Policy # \_\_\_\_\_

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Farnham of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

## HIPAA PRIVACY FORM (In Office ONLY) Acknowledgement of Receipt of Notice of Privacy Practices

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_, have received a copy/explanation of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Signature of Patient and/or Guardian} {Date} \_\_\_\_\_ (Relationship to Patient)  
(Relationship to Patient) Self or Other: \_\_\_\_\_