World Class Dentistry
Jill Morris, DMD * Burr Bakke, DDS

Medical Dental History Form
Date _____

PATIENT

Patient's Last Name _____ **First Name** _____ **Middle Initial** _____

Title Mr. Mrs. Ms. Miss. Other _____ **I prefer to be called** _____

Date of Birth _____ **Sex - Male** ___ **Female** ___ **Social Security #** _____

Marital Status: Single ___ **Married** ___ **Separated** ___ **Divorced** ___**Widowed** ___

Home Address _____

City _____**State**_____ **Zip Code** _____

Home Phone ( ) _____ **Cell ( )** _____ **Work ( )** _____

Email Address_____ **Occupation** _____

Gmail Address_____**@GMAIL.COM (For office communication only)**

Out of State Address _____

City _____ **State** _____ **Zip** _____

SPOUSE OR CLOSEST RELATIVE

Name _____ **Relationship** _____

Home Phone ( ) _____ **Cell ( )** _____

PHYSICIAN -Primary Care

Name _____**City, State** _____

Last seen _____ **Office Phone ( )** _____

How did you hear about us? _____

What concerns you about your teeth? _____

INSURANCE INFORMATION

Do you have Dental Insurance? ___ **Yes** ___ **No** **Name of Company** _____

Insurance Co Address _____

Name of insured _____ **Relationship** _____ **Group #** _____

Insured SS# or Insurance ID _____ **Insureds Date of Birth** _____

Employer _____

Patient _____

ALLERGIES

____NO KNOWN ALLERGIES

Yes	No		Which one
		Antibiotics	
		Aspirin	
		Barbiturates	
		Codeine	
		Iodine	
		Latex	
		Local anesthetics	
		Metals	
		Penicillin	
		Plastic	
		Sedatives	
		Sleeping pills	
		OTHER	
		OTHER	

DENTAL HISTORY

Now or in the past have you had any of the following?

YES	NO	
		Teeth removed?
		Chipped or injury to your teeth?
		Sensitive or sore teeth?
		Bleeding gums or bad taste or odor ?
		Jaw fracture, cyst or infection?
		Any root canals?
		Frequent canker sores or cold sores?
		Difficulty breathing through your nose?
		Food impaction between your teeth?
		Mouth breathing or snoring?
		Gasping or choking during sleep?
		Do you feel rested in the morning?
		Have you ever had a sleep study?
		Biting finger nails or objects? pencil, pen
		Abnormal/trouble swallowing?

Yes	No	
		Tooth grinding or clenching?
		Clicking or locking in jaw joints?
		Soreness in jaw or face muscles?
		Difficulty in chewing or opening jaw?
		Treated for TMJ or TMD ?
		Broken or missing fillings?
		Any serious problems with prior dental treatment?
		Diagnosed with gum disease or pyorrhea?
		Do you have Dry Mouth?
		Do you take Vitamin D3?
		Do you take Cholesterol medication?

YES	NO	
		Do you have back pain? Where ?
		Do you have shoulder pain?
		Hospitalized or Major Surgeries?
		List:
		Have you ever taken Bisphosphonates? ***See attached sheet for examples *
		List:
		When:
		For how long:
		IV, Injection or Pill:

Yes	No	
		Do you take Sedatives
		List:
		Do you take or have you taken Phen-Fen or Redux?
		Do you take any Sleep Aids? Prescription or Over-the-Counter
		List of Sleep aids:
		Have you been told that you need to **pre-medicate or take antibiotics before** dental procedures?
		Have you had **any joint replacement(s)**?
		Joint?
		Surgeon

How often do you brush?	
How often do you floss?	
How often do you use a waterpik?	
Do you chew tobacco?	
Do you smoke? Frequency	
Do you Vape?	
Do you drink coffee/tea? How much per day?	
Do you drink Alcohol? How much ?	

MEDICAL HISTORY

Do you have or have you experienced any of the following?

Patient _____

YES	NO	
		Anemia
		Anxiety
		Asthma
		Blood Pressure ___ High ___Low
		Bleed easily
		Bruise easily
		Birth Defects
		Cancer Type _____
		Celiac/Gluten Sensitivity
		Chemotherapy / Radiation Therapy
		Chronic Fatigue
		Cold hands or feet
		Depression
		Diabetes
		Difficulty concentrating
		Difficulty breathing during sleep
		Dizziness
		Excessive thirst
		Emphysema
		Epilepsy or seizures
		Fainting
		Fibromyalgia
		Fluid retention
		Frequent colds/flu/cough/sore throat/ear infections
		Frequent waking at night
		Frequently breathe through your mouth
		Glaucoma
		Heart attack/disorder
		Heart murmur
		Heart pacemaker
		Heart valve replacement
		Hemophilia
		Hepatitis ___A ___B ___C
		History of substance abuse
		Hyperlipidemia
		Hypoglycemia (low)
		Huntington's disease
		Hay fever
		Hearing impairment
		Indigestion/ reflux
		Insomnia
		Irregular heart beat
		Intestinal disorder
		Kidney Disease
		Leukemia
		Liver disease/ jaundice
		Mitral valve prolapse

YES	NO	
		Migraines
		Meniere's disease
		Multiple sclerosis
		Muscular dystrophy
		Muscle aches
		Muscle fatigue
		Muscle spasms
		Memory loss
		Nervous system disorder
		Neuralgia
		Osteoarthritis
		Osteoporosis
		Ovarian cyst
		Parkinson's disease
		Poor circulation
		Psychiatric care
		Rheumatic fever
		Rheumatoid arthritis
		Recent weight ___gain ____loss
		STD/ AIDS/ HIV/VD/ Herpes/Gonorrhea
		Scarlet fever
		Shortness of breath
		Sinus problems
		Skin disorders
		Sleep apnea
		Slow healing sores
		Speech difficulties
		Stroke
		Swollen, stiff or painful joints
		Thyroid problems
		Tuberculosis
		Urinary tract disorders
		Any injuries to face, head or neck ?
		Any immune system problems? LIST:
		History of eating disorders?
		Do you eat a well balanced diet?
		Do you have dry mouth?
		Pregnant or think you may be ?
		Nursing ?
		Taking oral contraceptives ?

ADDICTIONS

Are you or have you ever been addicted to any of the following?

YES	NO	
		Alcohol
		Meth
		Cocaine
		Oxycodone
		Heroin
		Other: List

If yes, when and for how long?

_____

_____

_____

MEDICATIONS

Patient Name _____

PLEASE LIST ANY AND ALL MEDICATIONS, SUPPLEMENTS AND OVER-THE-COUNTER DRUGS YOU ARE CURRENTLY TAKING or WRITE "NONE" if not taking anything: **PLEASE PRINT CLEARLY**

Medication Name	Dosage	Frequency	Reason that you are Taking

Preferred Pharmacy _____ Phone # _____
Location _____

If you have **Dental Implants** from another Practice, please provide: **What** kind of implant(s) _____

When it was done_____ **Where** it was done _____
City, State_____ Phone_____

To the best of my knowledge, all questions and information given on this form are accurate. I understand that providing the incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform this dental office (World Class Dentistry) of any changes in medical status and to update any demographic information.

I authorize the release of any dental/medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment, regardless of insurance coverage.

Patient Signature _____ Date _____

Patient Printed Name: _____

Reviewed by Hygienist: _____ Date _____

Reviewed by Doctor: _____ Date _____

Examples of Bisphosphonate Medications

And Similar Type Medications

This is not a complete list

Brand Name	Generic	How is it administered
Aclasta	Zoledronic Acid	Oral
Actonel with Calcium	Calcium Carbonate/ Risedronate	Oral
Actonel Atelvia	Risedronate	Oral
Aredia	Pamidronate	Oral/IV
Bonefos, Clasteon	Clodronate	
Binosto	Alendronate	Oral
Boniva	Ibandronate	Oral/IV
Didronel	Etidronate	Oral/IV
Fosamax	Alendronate	Oral
Fosamax Plus D	Alendronate / Cholecalciferol	Oral
Ostac	Clodronic Acid	
Skelid	Tiludronate	Oral
Zometa/Reclast	Zolendronate Zoledronic Acid	IV Injectable

OR

Forteo	Teriparatide	Injectable
Prolia /Xgeva	Denosumab	Injectable

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name (Print)_____Patient DOB_____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: _____complete records _____progress notes _____lab reports _____path reports _____surgical reports _____other specify_____

2. To whom may the information be released [name(s) or class of recipients]:_____

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release: This authorization ends: (box) on date: _____ (box) this authorization will expire automatically when the records requested on this form have been mailed to the requestor or within 180 days from date of sign, which ever comes first.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____

Cone Beam 3D Image& Ozone Application Consent Form

CONE BEAM 3D IMAGE CONSENT:

The Cone Beam 3D Imagel am having in the office of Drs. Morris and Bakke is at no charge today and is their sole property. If I choose a copy of my image, I will pay the sum of $350.00 before receiving such copy.

CONE BEAM 3DIMAGE RADIOLOGY READ RELEASE

I have been fully informed that I could have pathology that only a radiologist would discover and I choose not to have my image read. I hereby release Dr.'s Jill M. Morris DMD and Burr Bakke DDS, World Class Dentistry and Jill M. Morris DDS Inc. from and all liability resultant from the non-reading of my Cone Beam 3D Image by a certified Radiologist and/or Dental Radiologist.

OZONE APPLICATION CONSENT:

We are planning to use ozone (gas, water, oil) in the treatment of your oral/dental condition. The objective of using ozone in its many forms is to remove infection. It is effective against bacteria, fungi (yeast), viruses. Ozone has many remarkable properties in improving the body's ability to heal and enhance over-all well-being. For instance, it improves the strength of the immune system, increases oxygenation of body tissue and expands our anti-oxidant status. Most people respond very well to ozone treatments. As with any other medical procedure, how you will respond personally is never fully known.

There are very few side effects of ozone.Occasionally areas breakout in remote spots of the skin, these may be itchy patches or red areas. This occurs when the ozone kills off so many germs so rapidly that the body has to spend some time getting rid of all the breakdown products. This is known as a Herxheimer reaction and usually goes away in a few days. Please advise us of ANY events following your treatments so that we may manage your case appropriately.

If we will be using ozone gas, we will use a variety of procedures to avoid having you inhale the gas or get it into your eyes, since it can be irritating on these two human tissues. All other areas of the body –including the teeth and gums—tolerate ozone quite well and can benefit by controlled exposure. If you do happen to inhale a small quantity of the gas, it will usually result in a short period of coughing. This is very rare, but if it occurs, we will give you some chewable vitamin C. Asthmatics may have more pronounced irritation effects, so please advise us if you have an asthmatic condition.

We may use ozonated versions of olive oil, jojoba oil, or avocado oil. If you have allergies to any of these food items, please advise us before use. Naturally, if you have any unusual effect after applying any medicament, we want you to call us so we can advise and treat you accordingly. Other than a medicinal taste, side effects are extremely rare.

Standard informed consent advisory:

I have been given the opportunity to ask any questions I might have about the treatment objectives and procedures described above. I have been informed of the more commonly known and expected potential risks, benefits and alternatives. I have been given the option to seek treatment elsewhere or obtain a second opinion from other practitioners. I voluntarily assume any and all possible risk of harm—if any—which might be associated with any phase of this treatment, in hopes of obtaining the desired result, which may or may not be achieved. No guarantees or promises have been represented to me concerning these desired results. I may achieve no results, satisfactory results, or unsatisfactory results. If I am currently under the care of a physician or dentist for known or unknown condition(s), it is my responsibility to inform all practitioners of ALL other courses of treatment that I am receiving. My dentist has advised me that it is in my best interest to integrate all therapeutic modalities that are available to treat my health condition(s). I have received information on the fees attendant to these procedures, and I understand and accept these fees. I have received no promises as to coverage for these services by any third parties, and I accept full responsibility for these fees. With my signature I am giving permission to Dr. Bakke and/or Dr. Morris for any of the treatment(s) we have discussed. I understand that the Doctor is NOT my primary care physician, and I understand it is advisable to utilize the services and consult my primary care physician in conjunction with my dental care. I certify that I have read, discussed and understand the above information and hereby authorize my treatment including the use of medical/dental oxygen/ozone. I represent that I am seeking treatment in order to further my own health and for no other reason. I am aware that I may withdraw this consent at any time.

Name: (PLEASE PRINT)_____

Signature:_____Date:_____

Witness Name: (PLEASE PRINT)_____

Signature:_____Date:_____

Doctor: (PLEASE PRINT)_____

Signature:_____Date:_____