World Class Dentistry **Medical – Dental History Form**

Date _____ **Under 18 Years of Age**

❖ **Patient**

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

Date of Birth _____ M _____ F ____

Pediatrician/Primary Care _____ Phone _____

City, State _____ Last Visit _____

❖ **Parent/Guardian**

Parent Last Name _____ First Name _____ Middle Initial _____

Relationship to Patient _____ Home Phone _____

Cell Phone _____ Email address _____

Gmail Address _____@GMAIL.COM (For office communication only)

Address _____ City _____ State _____ Zip _____

How did you hear about us ?

Medical History

Please let us know if your child has or has had any of the following:

YES	NO	
		ADD/ADHD
		Anemia
		Asthma
		Autism
		Blood Pressure ____ High ____ Low
		Cerebral Palsy
		Chronic Hay Fever
		Cleft Lip/Palate
		Congenital Heart Defect
		Diabetes
		Downs Syndrome
		Epilepsy or Seizures
		Hearing Problems
		Heart Murmur
		HIV/Aids
		Juvenile Arthritis
		Pneumonia
		Psychiatric Care
		Rheumatic Fever
		Sensory or Speech Impairment
		Stutter or Lisp
		Vision Problems

YES	NO	
		History of a Major Illness
		List and When:
		History of Major Surgeries
		List and When:
		Often sick with colds and/or other infections?
		List and how often:
		Other Medical/Dental Conditions we should know about?
		List:
		Ever been involved in a serious accident?
		List and When:
		Eat a balanced Diet?
		Mouth Breather?
		Fingernail biter ?

Medications PLEASE PRINT

Prescription or Over-the- Counter or Vitamins

Rx/ OTC/ Vitamins	Dosage	Frequency

Patient _____

Allergies ____No known Allergies

YES	NO	
		Any Allergies ?
		(Medications, Foods, Latex, Etc.)
		List:

Insurance

YES	NO	
		Dental Insurance with Ortho Coverage ?
		Company:

Hygiene

Brush – How often?	
Waterpik- How often?	
Floss – How often?	

Does patient have any Addictions ?	

Does patient Chew?	Does patient smoke?	Does patient Vape?

Pediatric Dentist _____ Phone _____

City, State _____ Last Visit _____ Last X-rays _____

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 the 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 treatment, regardless of insurance coverage.

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Printed Name _____ Relationship _____

Reviewed by Ortho Staff _____ Date _____

Reviewed by Doctor _____ Date _____

Jill M. Morris, D.M.D. * Wilbur E. Bakke, D.D.S.**
3951 Swift Road
Sarasota, FL. 34231
Phone #: (941) 923-6363 * Fax #: (941) 922-3774
FrontOffice@sarasotadentist.com

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_____