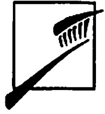
# Health History Form

**South Coast Dental**
**Dr. Lilia Larin DDS**



E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: Mailing address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

**Do you have any of the following diseases or problems:** ***(Check DK if you Don't Know the answer to the question)***

| | Yes | No | DK |
|---|---|---|---|
| Active Tuberculosis | ☐ | ☐ | ☐ |
| Persistent cough greater than a 3 week duration | ☐ | ☐ | ☐ |
| Cough that produces blood | ☐ | ☐ | ☐ |
| Been exposed to anyone with tuberculosis | ☐ | ☐ | ☐ |

***If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.***

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

| | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ |
| Does food or floss catch between your teeth? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY | | | |
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

| | Yes | No | DK |
|---|---|---|---|
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |

If yes, what condition is being treated?

Date of last physical exam:

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |

If yes, what was the illness or problem?

| | Yes | No | DK |
|---|---|---|---|
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

# Medical Information

***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.***

*(Check DK if you Don't Know the answer to the question)*

| | Yes | No | DK |
|---|---|---|---|
| Do you wear contact lenses? | ☐ | ☐ | ☐ |
| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ | ☐ |
| Date: ____________ If yes, have you had any complications? ____________ | | | |
| Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's diesease? | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresportive agent (Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ | ☐ |
| Date Treatment began: ____________ | | | |
| Do you use controlled substances (drugs)? | ☐ | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)? | ☐ | ☐ | ☐ |
| If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED | | | |
| Do you drink alcoholic beverages? | ☐ | ☐ | ☐ |
| If yes, how much alcohol did you drink in the last 24 hours? ____________ | | | |
| If yes, how much do you typically drink In a week? ____________ | | | |

**WOMEN ONLY** Are you:

| | Yes | No | DK |
|---|---|---|---|
| Pregnant? | ☐ | ☐ | ☐ |
| Number of weeks: ____________ | | | |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

**Allergies** - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

| | Yes | No | DK |
|---|---|---|---|
| Local anesthetics ____________ | ☐ | ☐ | ☐ |
| Aspirin ____________ | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics ____________ | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills ____________ | ☐ | ☐ | ☐ |
| Sulfa drugs ____________ | ☐ | ☐ | ☐ |
| Codeine or other narcotics ____________ | ☐ | ☐ | ☐ |
| Metals ____________ | ☐ | ☐ | ☐ |
| Latex (rubber) ____________ | ☐ | ☐ | ☐ |
| Iodine ____________ | ☐ | ☐ | ☐ |
| Hay fever/seasonal ____________ | ☐ | ☐ | ☐ |
| Animals ____________ | ☐ | ☐ | ☐ |
| Food ____________ | ☐ | ☐ | ☐ |
| Other ____________ | ☐ | ☐ | ☐ |

***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.***

| | Yes | No | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | | | |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

| | Yes | No | DK |
|---|---|---|---|
| Cardiovascular disease. | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Other congenital heart defects | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: ____________ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus. | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, specify: ____________ | | | |
| Sleep disorder | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Specify: ____________ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection: ____________ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ | ☐ |

Name of physician or dentist making recommendation: Phone:

| | Yes | No | DK |
|---|---|---|---|
| Do you have any disease, condition, or problem not listed above that you think I should know about? | ☐ | ☐ | ☐ |

Please explain:

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date

**FOR COMPLETION BY DENTIST**

Comments: ____________

# DENTAL TREATMENT CONSENT FORM

DENTIST'S NAME: Dr Lilla Larin ____________ PATIENT'S NAME: ______________________________

Please read and initial the items checked below and read and sign at the bottom of form.

**1. X-RAYS** (Initials__________)

**2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials__________)

**3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials________)

**4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present. It may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue(Paresthesia) that can last for an indefinite period of time(days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization. If complications arise during or following treatment, the cost of which is my responsibility.
(Initials__________)

**5. CROWNS, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
(Initials__________)

**6. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials__________)

**7. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the teeth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials__________)

**8. PERIODONTAL LOSS (TISSUE & BONE)**
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials__________)

**9. FILLINGS**
*I understand that care must be exercised in chewing on fillings* especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials__________)

**10. DENTURES**
I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included into the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more that 30 days there will be additional charges. (Initials________)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been make by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient________________________________________Date____________________

Signature of Parent/Guardian if patient is a minor________________________Date______________

CONSENT 2

South Coast Dental
Dr Lilla Larin, DDS
617-477-1970 (Ph)
617-477-6117 (Fax

**South Coast Dental**

## Cancellation Policy

We apologize for any inconvenience this notice may cause but in order to help standardize our appointment schedule and to help open up valuable time for fellow patients we require a 48 hour cancellation notice. If we do not receive a 48 hour cancellation notice you will be charged $35.00.

For specialist services the cancellation fee is $150.00.

Thanks for your cooperation.

________________________________________
Signature Date

## Poliza de Cancelacion

Perdone por cualquier inconveniencia que pueda causar este poliza pero para mantener un horario solido y beneficio para nuestros pacientes estamos pidiendo que porfavor si por cualquier motivo necesita cambiar o cancelar alguna de sus citas nos de un aviso previo con un minimo de 48 horas antes de la hora de su cita . Si no atiende a su cita o no cancela con un minimo de 48 horas antes sera necesario cobrarle $35.00 por la falta.

Servicios de especialista cancelados o fallados se cobran a $150.00 dlls.

Gracias por su cooperacion.

________________________________________
Firma Fecha

South Coast Dental

# ASSIGNMENT OF DENTAL INSURANCE BENEFITS

Welcome to our office! We are committed to providing you with the best possible dental care with kindness and professionalism. We are happy to work with you by submitting your insurance claims with participating insurance carriers but would like you understand our office policy regarding insurance assignment.

Please bear mind that your dental insurance is a contract between you, your employer and the insurance carrier. Generally, our fees fall within the range most insurance companies accept and are therefore covered up to maximum allowance allowed negotiated with each insurance company. However, not all services are covered benefits in every contract.

You acknowledge that it is your responsivity to:

1. Provide complete up-to date information on dental insurance coverage for the patient. This includes information on all plans, if enrolled in more then one plan.
2. Present a valid insurance card at each visit.
3. Pay your portion for services not covered at 100% (see above) at each visit.
4. Pay within 30 days any balance on your account for any amounts for any due this office such as deductibles, co-payment, non-covered services.
5. You are ultimately responsible to pay the dental bill if the assignment of benefits is not honored in whole or in part.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the dental insurance coverage information,
3. You authorize this office to release this office to release the information necessary to process your claims and appeals. .
4. You authorize payment of dental benefits to South Coast Dental.

_______________________________________________

Signature of Patient or Responsible Party          Date

**Patient information:**

Patient's Name ______________________ Date of Birth __________

**Subscribers Information:**

Subscribers Name ______________________ Date of Birth __________

Subscriber ID #______________________

Group ______________ Employers Name ______________________

______________________________________________

(Name of practice)

# ACKNOWEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND MATERIALS FACT DATA SHEET

*You May Refuse to Sign This Acknowledgement*

I, ______________________________________________ have received a copy of this office's Notice of Privacy Practices.

______________________________________________
Please Print Name

______________________________________________
Signature

______________________________________________
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please Specify)______________________________________________

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