Meadows
Family Dentistry
Dr. Preston Polson

**Annual Information Update** **Name** _____ **Date**_____

## HIPPA Policy

I have received a copy of this office's Notice of Privacy Practices and agree to the terms described in the policy.

**Yes** **No**

❑ ❑ _____
(Initials)

## Authorization to Discuss Dental Treatment

I authorize Meadows Family Dentistry to discuss my dental treatment needs and finances with the following individuals:

_____

_____

(Although oral health primarily involves your oral tissues and surrounding structures, your overall health and medical conditions influence the sequence and appropriate treatment of oral diseases. Your annual medical health review is an important part of providing ideal oral health care. Your answers are important and kept confidential.)

## Review of General and Oral Health

**(please X if you have or have had any of the following conditions)**

- ❍ Abnormal Bleeding
- ❍ AIDS/HIV
- ❍ Allergy/Anaphylaxis
- ❍ Anemia
- ❍ Angina
- ❍ Alzheimer's Disease
- ❍ Anti-coagulant therapy
- ❍ Arthritis
- ❍ Artificial Heart Valve
- ❍ Artificial Joint
- ❍ Asthma
- ❍ Bisphosphonates therapy
- ❍ Bleeding Gums
- ❍ Blood Disease
- ❍ Blood Transfusion
- ❍ Breathing Problems
- ❍ Bruise Easily
- ❍ Cancer
- ❍ Canker Sores
- ❍ Cardiovascular Disease
- ❍ Chemotherapy
- ❍ Clench/grind your teeth
- ❍ Cold Sores
- ❍ Congenital Heart Defect
- ❍ C-PAP
- ❍ Dental Trauma
- ❍ Diabetes
- ❍ Dizziness
- ❍ Dry Mouth
- ❍ Eating Disorder
- ❍ Emphysema
- ❍ Epilepsy/Seizures
- ❍ Epinephrine Sensitive
- ❍ Excessive Bleeding
- ❍ Fainting
- ❍ Frequent Cough
- ❍ Frequent Diarrhea
- ❍ Frequent Headaches
- ❍ GE Reflux
- ❍ GI Problems
- ❍ Glaucoma
- ❍ Head Injuries
- ❍ Heart Attack
- ❍ Heart Disease
- ❍ Heart Murmur
- ❍ Hemophilia
- ❍ Hepatitis A, B, or C
- ❍ Hives/Rash
- ❍ Hypertension
- ❍ Hypoglycemia
- ❍ Irregular Heart Beats
- ❍ Immune Compromised
- ❍ Jaundice
- ❍ Jaw Popping/Clicking
- ❍ Kidney Problems
- ❍ Liver Disease
- ❍ Lock Jaw open/closed
- ❍ Low Blood Pressure
- ❍ Lung Disease
- ❍ Mental Health Disorders
- ❍ Migraines
- ❍ Mitral Valve Prolapse
- ❍ Osteoporosis
- ❍ Pace Maker
- ❍ Pain in Jaw Joint
- ❍ Periodontal Disease
- ❍ Pregnancy
- ❍ Psychiatric Care
- ❍ Radiation Treatments
- ❍ Recent Weight Changes
- ❍ Renal Dialysis
- ❍ Rheumatic Fever
- ❍ Rheumatism
- ❍ Sickle Cell Disease
- ❍ Seizures/Convulsions
- ❍ Shingles
- ❍ Sinus Trouble
- ❍ Sleep Apnea
- ❍ Stomach Problems
- ❍ STD
- ❍ Stroke
- ❍ Swollen Lymph Nodes
- ❍ Thyroid Disease
- ❍ TMD
- ❍ Tuberculosis
- ❍ Tumors or Growths
- ❍ Ulcers

Have you had any other medical diseases, conditions, or problems in the last year that are not listed above? _____

_____

**Yes No**

❑ ❑ Have you seen a physician(s) in the last year? If yes, name of Physician(s) _____

_____

condition(s) being treated _____

❑ ❑ Have you been hospitalized or had any operations in the last year? (please list operation(s) _____

_____

❑ ❑ Have you had a change in medications or new medications in the last year. (List below)

❑ ❑ Have you developed any new allergies that have not been noted?

❑ local anesthetics ❑ aspirin ❑antibiotics ❑codeine /narcotics ❑ latex ❑ metals(jewelry)

If yes specify the type of reaction_____

**Women** are you: ❑nursing ❑taking oral contraceptives or ❑ is there a chance you may be pregnant?

**Oral Cancer Risk Factors**

**Yes No**

❍ ❍ Do you use tobacco products or Vape? (smoke, chew, vape, snuff) if yes, how many pack(s)/day_____ # of years _____

❍ ❍ Do you drink alcoholic beverages? If yes how often ❍socially ❍weekly ❍daily

❍ ❍ Have you ever used drugs or substances for recreational purposes? If yes please note_____

Are you experiencing any dental pain, sensitivity or concerns that need to be addressed?

_____

Please list all your current medications: (Medication, Condition Being Treated, Dose)

_____

_____

_____

_____