**Dental History and Dental Consent**

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Have you had problems with prior dental treatment?** Yes □ No □ Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you in pain now?** Yes □ No □ Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever taken Oral or IV Bisphosphonates prescribed by your medical provider to prevent Osteoporosis/bone loss?** (such as Fosamax, Actonel, Boniva, Aredia, Zometa, Bonefos) Yes □ No □

**Physician’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Last Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do any of the following conditions apply to you?** \_\_\_ Prosthetic Heart Valve \_\_\_ Hepatitis \_\_\_ Radiation Treatment \_\_\_ Sickle Cell Disease / Trait\_\_\_ Mitral Valve Prolapse \_\_\_ Heart Surgery \_\_\_ Prosthetic Joint Replacement

**Are you in recovery from drugs or alcohol?** Yes □ No □

**Women Only:** Are you or could you be pregnant? Yes □ No □ Months: \_\_\_\_ Are you nursing a baby? Yes □ No □ Are you using Birth Control Pills? Yes □ No □

Patient Consent: By signing this form I give my consent to dental providers at Project HOME to perform dental treatment and/or oral surgery procedure(s) on myself, my child, or my legal dependent, including the use of any necessary or advisable local anesthetics, medications, radiographs (x-rays), or diagnostic procedures as may be necessary or advisable for any proper dental treatment. I recognize that during the course of dental treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable for oral health and well-being in the professional judgment of the dentists at Project HOME I hereby request that any payment of authorized Medicaid, MA HMO, or commercial insurance benefits be made, on my behalf, directly to Project HOME for any services furnished to me by their medical, dental, behavioral health or social work staff. I understand that I am financially responsible for all fees charged for my treatment, even if not covered by my insurance benefits. I further consent to the release of my protected health information to enable Project HOME to carry out treatment, healthcare operations or to bill for payment of benefits. With this consent, I authorize Project HOME to mail to my home address (or other address that I provide) any items that assist the practice in carrying out treatment, billing or health care operations such as appointment reminders or patient statements. I further acknowledge that I have been given a copy of the Project HOME Notice of Privacy Practices as required by HIPAA.

I understand that the above information is necessary to provide me with dental care is a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, I give Project HOME permission to ask the respective health care provider or agency, who may release such information. I will notify the doctor of any change in my health or medication.

Patient/Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_