

# Health History Form

Email: \_\_\_\_\_ 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: <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ( )		Business/Cell Phone: <i>Include area code</i> ( )		
Address: <i>Mailing address</i>			City:		State: Zip:		
Occupation:			Height:		Weight:		
			Date of Birth:		Sex: M F		
SS# or Patient ID:		Emergency Contact:		Relationship:		Home Phone: <i>Include area code</i> ( )	
						Cell Phone: <i>Include area code</i> ( )	
If you are completing this form for another person, what is your relationship to that person?							
<i>Your Name</i>				<i>Relationship</i>			
<b>Do you have any of the following diseases or problems:</b>				<i>(Check DK if you Don't Know the answer to the question)</i>			<b>Yes No DK</b>
Active Tuberculosis.....							□ □ □
Persistent cough greater than a 3 week duration.....							□ □ □
Cough that produces blood.....							□ □ □
Been exposed to anyone with tuberculosis.....							□ □ □
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>							

## Dental Information *Please mark (X) your responses to the following questions.*

Yes No DK			Yes No DK		
Do your gums bleed when you brush or floss?..... □ □ □			Do you have earaches or neck pains?..... □ □ □		
Are your teeth sensitive to cold, hot, sweets or pressure?..... □ □ □			Do you have any clicking, popping or discomfort in the jaw?..... □ □ □		
Is your mouth dry?..... □ □ □			Do you brux or grind your teeth?..... □ □ □		
Have you had any periodontal (gum) treatments?..... □ □ □			Do you have sores or ulcers in your mouth?..... □ □ □		
Have you ever had orthodontic (braces) treatment?..... □ □ □			Do you wear dentures or partials?..... □ □ □		
Have you had any problems associated with previous dental treatment?..... □ □ □			Do you participate in active recreational activities?..... □ □ □		
Is your home water supply fluoridated?..... □ □ □			Have you ever had a serious injury to your head or mouth?..... □ □ □		
Do you drink bottled or filtered water?..... □ □ □			Date of your last dental exam:		
If yes, how often? <i>(Check one:)</i> DAILY □ / WEEKLY □ / OCCASIONALLY □			What was done at that time?		
Are you currently experiencing dental pain or discomfort?..... □ □ □			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			Yes No DK		
Are you now under the care of a physician?..... □ □ □			Have you had a serious illness, operation or been hospitalized in the past 5 years?..... □ □ □		
Physician Name: _____ Phone: <i>Include area code</i> ( )			If yes, what was the illness or problem?		
Address/City/State/Zip:			Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... □ □ □		
Are you in good health?..... □ □ □			If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:		
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:			_____		

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

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Do you use controlled substances (drugs)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? <i>Circle one:</i> VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p><b>WOMEN ONLY</b> Are you:</p> <p>Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p><b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.</p> <p>Local anesthetics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cocaine or other narcotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Metals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

<p style="text-align: center;"><b>Yes No DK</b></p> <p>Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: center;"><b>Yes No DK</b></p> <p>Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: center;"><b>Yes No DK</b></p> <p>Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

<p style="text-align: center;"><b>Yes No DK</b></p> <p>Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: center;"><b>Yes No DK</b></p> <p>Mitral valve prolapse ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code*  
(    )

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Appointment Policy

Our goal is to provide quality dental care in a timely manner. In order to do so, we ask that patients adhere to our cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

### **CANCELLATION OF AN APPOINTMENT**

We request that you notify us at least 24 hours in advance if you need to cancel or reschedule your appointment. Cancellations made with less than 24 hours' notice may be subject to a \$50.00 fee.

### **NO SHOW POLICY**

A "no-show" occurs when a patient fails to arrive for their scheduled appointment without notifying the office. A no-show will result in a \$50.00 to \$75.00 fee per scheduled hour.

Two (2) or more missed appointments or late cancellations in a 12-month period may result in dismissal from our practice.

### **LATE ARRIVALS**

We strive to start all appointments on time. If you arrive more than 7 minutes late for your appointment, we may need to reschedule your appointment to avoid delaying other patients. If time permits, we may be able to complete a portion of the scheduled work, or you may need to wait for an opening on the same day.

### **APPOINTMENT CONFIRMATIONS**

To ensure our schedule runs smoothly, we require confirmation for all scheduled appointments.

As a courtesy, we send appointment reminders in advance via text, email, and phone call. We ask that you respond to the confirmation request within 24 hours of your scheduled appointment.

If an appointment remains unconfirmed 24 hours prior to the scheduled time, we reserve the right to cancel the appointment and offer the time slot to another patient.

This policy allows us to treat as many patients as possible by replacing unconfirmed appointments with patients who are on a waiting list. Utilizing this system allows us to quickly replace a "schedule opening" with another patient eager to see the dentist. We value each of our patients and believe this process benefits everyone. Your cooperation in this matter is greatly appreciated.

### **ACKNOWLEDGEMENT**

My signature below indicates that I have read, understood and agree to the appointment confirmation policy above.

\_\_\_\_\_  
Email

\_\_\_\_\_  
Cell phone

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Responsible Party



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(401) 821-5864 info@smilingri.com

## **Notice of Privacy Practices — Summary**

### **Effective Date: February 16, 2026**

This summary explains how Coventry Family Dental may use and disclose your health information and describes your privacy rights. A full Notice of Privacy Practices is available upon request.

### **Our Legal Responsibilities**

We are required by law to:

- Protect the privacy of your health information
- Provide you with this Notice
- Follow the privacy practices described here

### **How We May Use and Share Your Health Information**

We may use and disclose your health information for the following purposes:

#### **Treatment**

To provide, coordinate, or manage your dental care, including sharing information with other healthcare providers involved in your care.

#### **Payment**

To bill and receive payment from insurance companies or other payers.

#### **Health Care Operations**

For practice operations such as quality improvement, staff training, licensing, and business management.

#### **As Required or Permitted by Law**

Including public health activities or to prevent a serious threat to health or safety.

### **Special Privacy Protections for Substance Use Disorder Records**

(42 C.F.R. Part 2)

Some records related to substance use disorder diagnosis, treatment, or referral are protected by federal law and have stricter confidentiality requirements.

Coventry Family Dental may receive this information as part of your health history or through coordination of care.

These records may be used or disclosed:

- With your written consent, or
- Without your consent only when allowed by federal law, such as for medical emergencies or certain audits or court orders

Federal law generally prohibits re-disclosure of this information unless specifically permitted.

### **Certain Information Has Extra Protection**

Some types of health information, including substance use disorder records, are subject to additional protections under federal or state law. We follow all applicable laws when handling this information.

### **Your Privacy Rights**

You have the right to:

- See or get a copy of your health records
- Ask us to correct your records
- Request limits on how we use or share your information
- Request confidential communications
- Receive a list of certain disclosures
- Get a paper copy of this Notice at any time

### **Changes to This Notice**

We may change this Notice, and any changes will apply to all health information we maintain. Updated Notices will be available in our office and on our website.

### **Questions or Complaints**

If you have questions or believe your privacy rights have been violated, contact us or file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

### **Acknowledgment Of Receipt**

Please sign and date to acknowledge that you received this Notice of Privacy Practices

Name: \_\_\_\_\_

Date: \_\_\_\_\_