Devin Gapstur DMD
FAMILY, COSMETIC, & IMPLANT DENTISTRY

MEDICAL HISTORY

Name: ______________________________ **DOB:** _________________

Have you ever had an allergic reaction to:

- ❑ Acetaminophen/Tylenol®
- ❑ Acrylic
- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Erythromycin
- ❑ Fluoride
- ❑ Food
- ❑ Ibuprofen/Motrin®/Advil®
- ❑ Iodine
- ❑ Latex
- ❑ Local anesthetic
- ❑ Metals
- ❑ Morphine
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Other__________________

Are you taking any prescription or over-the counter medications?
☐ Yes ☐ No If yes, please list:

____

____

____

____

Date of last physical examination ____________ Are you currently being treated by a primary care physician? ☐ Yes ☐ No

Do you currently or have you in the past taken any bisphosphonate medication for osteoporosis (ie. Fosamax, Actonel, Boniva, Prolia, Reclast) or treated with the chemotherapy medications Zometa or Aredis? ☐ Yes ☐ No

If yes, which medication(s)? ____

Indicate which of the following you have had or have at the present: (Check all that apply)

- ❑ Abnormal/excessive bleeding
- ❑ AIDS/HIV infection
- ❑ Alcohol addiction
- ❑ Alzheimer's/Dementia
- ❑ Anemia
- ❑ Angina/Chest pain
- ❑ Anxiety
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Back problems
- ❑ Blood disease/disorder
- ❑ Blood transfusion
- ❑ Breathing/respiratory problems
- ❑ Cancer; Type: ___________
- ❑ Chemo./Radiation treatment
- ❑ Cold sores/fever blisters
- ❑ Congenital Heart Lesion
- ❑ Cardiovascular disease
- ❑ Chronic pain
- ❑ Congestive heart failure
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Eating disorder
- ❑ Emphysema
- ❑ Epilepsy/seizures
- ❑ Fainting spells
- ❑ Frequent headaches
- ❑ Gastrointestinal disease
- ❑ Glaucoma
- ❑ Heart Disease or Attack
- ❑ Heart rhythm disorder
- ❑ Hemophilia
- ❑ Hepatitis/jaundice/liver disease
- ❑ High blood pressure
- ❑ Hypoglycemia
- ❑ Kidney disease
- ❑ Mitral Valve Prolapse
- ❑ Neurological disorders
- ❑ Osteoporosis/Paget's disease
- ❑ Heart Pacemaker
- ❑ Psychiatric Care
- ❑ Severe headaches/migraines
- ❑ Severe or rapid weight loss
- ❑ Sexually transmitted infection
- ❑ Sinus trouble
- ❑ Sleep apnea
- ❑ Stroke
- ❑ Thyroid disease
- ❑ TMJ disorder
- ❑ Tobacco Use
- ❑ Tuberculosis
- ❑ Ulcer

Do you have any disease, condition, or problem not listed? ☐ Yes ☐ No
If yes, please explain ____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? ☐ Yes ☐ No
If yes, please explain ____

Have you had an orthopedic joint (ie. Hip, knee, elbow, finger) replacement? ☐ Yes ☐ No
If yes, please list the approximate date of replacement, which joint, and any complications. ____________________

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No
Name of physician making this recommendation: __________________ Physician's Phone #: _______________

WOMEN: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Name: ____________________ **DOB:** _______________

Date of your last dental visit: __________

Have you had any problems associated with previous dental treatment? ☐ Yes ☐ No
If so, please explain:____

Have you ever had periodontal treatment (ie. "deep cleaning", periodontal surgery)? ☐ Yes ☐ No
Date(s) of this periodontal treatment: ____

Have you ever worn braces or clear orthodontic aligners? ☐ Yes ☐ No

Do you currently smoke or use smokeless tobacco? ☐ Yes ☐ No

Have you previously smoked or used smokeless tobacco? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you experience pain in your jaw joints or facial muscles? ☐ Yes ☐ No
Have you received treatment for your jaw joints or facial muscles (ie. Therapeutic Botox®, TMJ surgery) ? ☐ Yes ☐ No
Date(s) of this treatment: ____

Do you wear any removable dental appliances (ie. Denture, partial, night guard, retainer)? ☐ Yes ☐ No

Do you have any specific questions or concerns about your oral health? ☐ Yes ☐ No
If yes, please explain ____

Are there any ways in which you would like to improve your smile (ie. Whitening, Porcelain veneers/crowns, orthodontic alignment of teeth)? ☐ Yes ☐ No
If yes, please explain ____

Are you interested in softening any facial lines using Botox® treatment? ☐ Yes ☐ No

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CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patient's Legal Name Last First MI		Prefer to be called/Nickname
Date of Birth ☐ Under Age 18	Gender	SSN
Home Phone #	Mobile Phone #	Email

Patient's Address Street Apt. # City State Zip Code

Occupation	Who may we thank for referring you to our office?
Other family members that are patients here	Responsible Party Name, Address, Phone #, DOB, & SSN (if someone other than the patient)

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

Name	Relationship
Home phone #	Mobile Phone #

DENTAL INSURANCE & FINANCIAL INFORMATION

Insurance Coverage ☐ YES☐ NO	Insurance Company Name	Insurance Address	Insurance Phone
Subscriber's Name	Patient's Relationship to Subscriber ☐SELF ☐SPOUSE ☐DEPENDENT	Subscriber's Birth Date	SSN
Group Number	Employer	Employer's Address	
Insurance Coverage ☐ YES ☐ NO	Insurance Company Name	Insurance Address	Insurance Phone
Subscriber's Name	Patient's Relationship to Subscriber ☐ SELF ☐ SPOUSE ☐ DEPENDENT	Subscriber's Birth Date	SSN
Group Number	Employer	Employer's Address	

Name: ________________________ **DOB:** _______________

REQUEST FOR CONFIDENTIAL COMMUNICATION

Unless you indicate a preference to **not** be contacted by a method, our office utilizes multiple methods of communication with our patients.

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home/Leave messages on my home voicemail	☐	☐
Contact me via cell phone/Leave messages on my cell phone voicemail	☐	☐
Contact me via email	☐	☐

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	Others/Family Members: (Please Print)
Health Care Providers ☐ YES ☐ NO Insurance Companies ☐ YES ☐ NO	1. 2.

NOTICE OF PRIVACY PRACTICES

________ initials — I have received a copy of the Notice of Privacy Practices of Devin Gapstur, D.M.D. P.A.
I hereby authorize, as indicated by my initials, Devin Gapstur, D.M.D. P.A. to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

________ initials — I provide the staff of Devin Gapstur, D.M.D. P.A. consent to discuss limited personal health information with anyone who transports me to and from an appointment when I am sedated. Examples might include how your treatment went or instructions for any post-treatment care.

ASSIGNMENT & RELEASE

________ initials — I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of video, photographs, and x-rays of the dental treatment that I receive before, during, and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations, and/or presentations without compensation to me. If I am signing this form as the guardian of a patient, then the above authorization is on behalf of such patient.

________ initials — By signing below, I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

FINANCIAL POLICY

________ initials — The cost of each visit and/or in office procedure is payable at time of your visit. You may pay by cash, check, Visa, MC, Amex, or Discover. If financing is needed, we offer Care Credit for your convenience. We schedule certain time slots for you to minimize waiting time. Please give us 48 hour notice if you are unable to keep your scheduled appointment in order to avoid the unnecessary broken appointment charge of $75. (if multiple appointments on same date, ie. With Hygienist and Doctor, multiple family members, this charge will be at the doctor's discretion).

________ initials — To duplicate or email radiographs, the patient must first sign a release form. There will be a $30 charge for this service. If there are numerous x-rays to be copied, there may be additional charges incurred.

________ initials — As a courtesy to you, our office will file your insurance claim for your visit. Since we are not a party to your agreement with your insurance company, it would be wise for you to determine why they have not paid or paid less than originally expected. Also, please try to keep track of your maximums and frequency limits for exams and cleanings. If we do not receive payment from your insurance company within 90 days, we ask that you pay the balance in full.

________ initials — Unfortunately, failure to meet financial obligations may result in referral to a collection agency or court action. Any collection, postage and/or legal fees incurred in the pursuit of collection are the patient's responsibility.

Signature of Patient (or Parent if minor): ____ Date: ____________________