**FONES DENTAL HYGIENE HEALTH CENTER HEALTH HISTORY and CONSENT FORM**

**Name:** _____ **Date:** _____
Last First Middle

**Home Phone Number:** _____ **Cell Number:** _____ **Business Number:** _____

**Address:** _____
Street City State Zip Code

**Occupation**: _____ **UB Student**: _____ **Email Address**: _____
*Yes/No* *For sending UB Clinics newsletter communication.*

**Date of Birth**: _____ /_____/_____ **Gender**: _____ **Height:** _____ **Weight:** _____

**Ethnicity:** (Please check appropriate box)

| | |
|---|---|
| ☐ African American | ☐ Indian (India) |
| ☐ Asian | ☐ Native American/Alaskan |
| ☐ Caucasian | ☐ Native Hawaiian/Pacific Islander |
| ☐ Haitian | ☐ Other: |
| ☐ Hispanic | |

***Cultural diversity related your dental treatment is an important part of oral health assessment. Please relate any additional relevant information.***

**In case of emergency whom may we contact?**
Name _____
Phone number _____
Relationship _____

**For safe, personalized dental hygiene care, a complete and accurate health history is necessary. Dental procedures may complicate or be complicated by existing conditions elsewhere in the body; general health factors influence response to care. Please give each question careful consideration. For each question, please indicate YES or NO, whichever applies, and comment as necessary. Your answers are for our records only and will be kept confidential in accordance with applicable laws.**

**Primary Care Physician**: _____
Phone Number

**Address**: _____
City State Zip Code

**Specialist / Physician**: _____
Phone Number

**Address**: _____
City State Zip Code

**When was your last medical visit?** _____ **What type of care did you receive?** _____

**Name of Dentist:** _____ **Address:** _____
**When was your last dental visit?** _____ **What type of dental care did you receive?** _____

**This consent area is your consent for dental care, which assumes that you are mentally competent, 18 years or older, and can read and write English.** If the patient cannot read and understand this form, an interpreter will explain the information on this form and acknowledge below that the patient has been informed about the nature of the services, understands what is to be done and consents to the work. **I Understand that:**

1. Fones School of Dental Hygiene is a teaching institution. Its main purposes are to educate and graduate qualified dental hygienists. Preventive services at the School are provided at the Fones Dental Hygiene Health Center, UB Clinics Health Sciences Center. These services will generally exceed the length of time required for the same services provided in a private practice setting.

2. Fones Dental Hygiene Health Center provides only preventive services. If your case requires treatment in addition to our services, we will advise you to seek private care. Services rendered at Fones Dental Hygiene Health Center do not replace the need to go to your dentist for regular examinations.

3. As a patient, I will provide my medical and dental histories to the best of my knowledge. To provide quality care without endangering anyone, we need full disclosure. It may be necessary to contact the office of your dentist or physician before we provide you with service.

4. Fones School of Dental Hygiene may use and disclose my records only for each of the following purposes: treatment, payment, health care operations, health care reminders, disaster relief, and for public benefit, including research purposes. Any other disclosure will require your written authorization.

5. X-rays, photographs, or fluoride treatments may be recommended based on patient need. **Do you agree to have** (please circle)
**X-rays ---- YES NO Photographs --- YES NO Sealants --- YES NO Fluoride Treatments ---- YES NO**
If you object to any or all of these procedures, they will not be performed.

**All records and materials concerning your care become the property of *Fones School of Dental Hygiene, University of Bridgeport.* Information will not be released without your consent, except to comply with public or private payment plans or for instructional purposes, and as indicated in # 4 above. Duplicate radiographs and notification of evaluation results and treatment may be sent to your private dentist upon request. I have read, understand and agree to the conditions as described above.**

_____ _____
**Signature** (Client/patient, Parent, Legal Guardian) **Date** Acknowledgement of Interpreter (If necessary) Date

**Fones Dental Hygiene Health Center**
**Medical History II**

**Patient Name:** _____ **Birth Date:** _____ **Date Created:** _____

**Are you a patient at another University clinic?**
**No_____ No, but I would like more information____ Yes_____ If yes, choose all that apply:**

| | | | |
|---|---|---|---|
| **Acupuncture** | **__ Yes __ No** | **Chiropractic** | **__ Yes __ No** |
| **Naturopathic** | **__ Yes __ No** | **Generative Medicine** | **__ Yes __ No** |
| **Pediatric & Autism** | **__ Yes __ No** | **Other** | **__ Yes __ No** |

If Yes noted, please expain

**Are you under a physician's care now?** **__ Yes __ No If yes** _____
**Have you ever been hospitlized or had a major operations?** **__ Yes __ No If Yes** _____
**Have you ever had serious head or neck Injury?** **__ Yes __ No If Yes** _____
**Are you taking any medications, pills, or drugs?** **__ Yes __ No If Yes** _____
**Do you take, or have you taken, Phen-Fen or Redux?** **__ Yes __ No If Yes** _____
**Have you ever taken Fosamax, Boniva, Actonel or Any other medications containing bisphosphonates?** **__ Yes __ No If Yes** _____
**Are you taking a prescription blood thinner?** **__ Yes __ No If Yes** _____

**Do you now or have you ever smoked cigarettes or used tobacco products?** **__ Yes __ No If Yes** _____

**If you use tobacco, nicotine, or any of the following, please indicate.**

| | | | | | |
|---|---|---|---|---|---|
| **Cigarettes** | **__ Yes __ No** | **Cigars** | **__ Yes __ No** | **Dip/Chew** | **__ Yes __ No** |
| **E-Cigarette** | **__ Yes __ No** | **Pipe** | **__ Yes __ No** | **Hookah** | **__ Yes __ No** |
| **Other** | **__ Yes __ No** | | | | |

**How often do you use tobacco or the above listed product(s)? (Ex: 1 pack/day)** _____
**How long have you been using tobacco or the above listed product(s)? (Ex: 8 years)** _____
**Do you use controlled substances? __ Yes __ No If Yes** _____

**Women: Are you… __ Pregnant/Trying to get pregnant? __ Nursing? __ Taking Oral Contraceptives?**

**Are you allergic to any of the following?**

| | | | |
|---|---|---|---|
| **__ Aspirin** | **__ Penicillin** | **__ Codeine** | **__ Acrylic** |
| **__ Metal** | **__ Latex** | **__ Sulfa Drugs** | **__ Local anesthetics** |
| **__ Dairy** | **__ Nuts** | **__ Gluten** | |
| **__ Other** | **If Yes, explain** _____ | | |

**Do you have, or have you had, any of the following:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Aids/HIV Positive** | **__ Yes __ No** | **Alzheimer's Disease** | **__Yes __ No** | **Anaphylaxis** | **__ Yes __ No** | **Anemia** | **__ Yes __ No** |
| **Asthma** | **__ Yes __ No** | **Arthritis/Gout** | **__ Yes __ No** | **Artificial Heart Value** | **__ Yes __ No** | **Artificial Joint** | **__ Yes __ No** |
| **Bruise Easily** | **__ Yes __ No** | **Cancer** | **__ Yes __ No** | **Chemotherapy** | **__ Yes __ No** | **Diabetes** | **__ Yes __ No** |
| **Drug Addiction** | **__ Yes __ No** | **Easily Winded** | **__ Yes __ No** | **Emphysema** | **__ Yes __ No** | **Epilepsy/Seizures** | **__Yes __ No** |
| **Excessive Bleeding** | **__ Yes __ No** | **Excessive Thirst** | **__ Yes __ No** | **Fainting Spells/Dizziness** | **__Yes __ No** | **Frequent Cough** | **__ Yes __ No** |
| **Frequent Diarrhea** | **__Yes __ No** | **Frequent Headaches** | **__ Yes __ No** | **Genital Herpes** | **__ Yes __ No** | **Glaucoma** | **__ Yes __ No** |
| **Hay Fever** | **__ Yes __ No** | **Heart Attack/Failure** | **__Yes __ No** | **Heart Murmur** | **__ Yes __ No** | **Heart Pace Maker** | **__ Yes __ No** |
| **Herpes** | **__ Yes __ No** | **High Blood Pressure** | **__Yes __ No** | **Hives or Rash** | **__ Yes __ No** | **Hypoglycemia** | **__ Yes __ No** |
| **Irregular Heartbeat** | **__ Yes __ No** | **Kidney Problems** | **__ Yes __ No** | **Leukemia** | **__ Yes __ No** | **Liver Disease** | **__ Yes __ No** |
| **Low Blood Pressure** | **__ Yes __ No** | **Lung Disease** | **__ Yes __ No** | **Mitral Valve Prolapse** | **__Yes __ No** | **Pain in Jaw Joint** | **__ Yes __ No** |
| **Parathyroid Disease** | **__ Yes __ No** | **Psychiatric Care** | **__ Yes __ No** | **Radiation Treatments** | **__ Yes __ No** | **Recent Weight loss** | **__ Yes __ No** |
| **Renal Dialysis** | **__ Yes __No** | **Rheumatic fever** | **__ Yes __ No** | **Rheumatism** | **__ Yes __ No** | **Scarlet Fever** | **__ Yes __ No** |
| **Shingles** | **__ Yes __No** | **Sickle Cell Disease** | **__ Yes __ No** | **Sinus Trouble** | **__ Yes __ No** | **Spina Bifida** | **__ Yes __ No** |
| **Stomach/Intestinal Disease** | **_ Yes __ No** | **Stroke** | **__ Yes __ No** | **Swelling of Limbs** | **__ Yes __ No** | **Thyroid Disease** | **__ Yes __ No** |
| **Tonsillitis** | **__ yes __ No** | **Tuberculosis** | **__ Yes __ No** | **Tumors or Growth** | **__ Yes __ No** | **Ulcers** | **__ Yes __ No** |
| **Venereal Disease** | **__ Yes __ No** | **Yellow Jaundice** | **__ Yes __ No** | | | | |

**Have you ever had any serious illness (including MRSA infection) not listed above? __ Yes __ No**
**If yes, explain** _____

**In the last 30 days, have you traveled outside the United States? __ Yes __ No**
**If yes, explain** _____
**Comments:**

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**X**_____ **Date:** _____
Signature of Patient, Parent or Guardian