Gregory S Rutherford, DDS
Specialist in Prosthodontics
Crowns, Bridges, Implant Restorations, Dentures & Partials
Cosmetic Dentistry and Sleep Apnea
3300 S Tamiami Trail Suite 1
Sarasota, Fl 34239 941-365-5235

Health History Form

Patient Information

Name_____Date_____
Mailing Address_____
City_____State_____Zip_____
Date Of Birth_____ SSN_____
Cell Phone_____Home Phone_____
Email_____Marital Status: Married, Single, Divorced, Widowed

Whom may we thank for referring you?_____

Do you have any of the following diseases or problems?
Active Tuberculosis ? .....Y or N
Chronic cough greater than 3 weeks duration?.....Y or N
A cough that produces blood?.....Y or N
Have you been exposed to anyone with TB?.....Y or N

Emergency Contact Information

Name_____Relationship_____
Home Number_____Cell Number_____

We do not accept dental insurance for payment. We will gladly help to file claims by filling out claims and mailing them in. If you have dental insurance, please let us make a copy of your card.

Dental Information

Do your gums bleed when you brush or floss?.....Y or N
Are your teeth sensitive to hot,cold,sweets or pressure?..... Y or N
Does food or floss catch between your teeth?.....Y or N
Is your mouth dry?.....Y or N
Have you ever had periodontal(gum) surgery?.....Y or N
Have you ever had orthodontic(braces) treatment?.....Y or N
Have you ever had any problems associated with previous dental treatments?.....Y or N
Do you need to take antibiotics prior to dental work?.....Y or N
If yes, What is the reason?_____

Is your home water supply fluoridated? .....Y or N
Do you drink bottled or filtered water?.....Y or N
If yes, how often? Daily Weekly Occasionally
Are you currently experiencing dental pain or discomfort?.....Y or N
Do you experience neck or ear pain?.....Y or N
Do you have any clicking,popping or discomfort in your jaw?.....Y or N
Do you brux or grind your teeth?.....Y or N
Have you been told you snore or hold your breath while sleeping? .....Y or N
Do you have sores or ulcers in your mouth?.....Y or N
Do you wear dentures or partials?.....Y or N
Who is your current dentist? _____
When was your last dental exam? _____
Date of last dental X-rays? _____
What is the reason for today's visit? _____

_____

How do you feel about your smile? _____

_____

Medical Information

Are you under the care of a physician?.....Y or N
If yes, what is your physician's name? _____
Are you in good health?.....Y or N
Any major health changes in the last year?.....Y or N
If yes, what are you being treated for?_____
When was your last physical exam?_____
Have you had a serious illness,operation or been hospitalized in the last five years?.....Y or N
If so, what was the illness or problem?_____

Please provide a list of all current medications: _____

_____

_____

Do you take an antibiotic before dental treatment? Y or N

If so which antibiotic?

Have you ever had a complete joint replacement of either the knee, hip, shoulder? Y or N if so, what date?_____

Have you ever been treated with Fosamax or any other bisphoshonates for osteoporosis, Padget's disease, multiple myeloma, metastatic cancer, etc ?.....Y or N
Do you use controlled substances?.....Y or N
Do you use tobacco?.....Y or N
Do you drink alcoholic beverages?..... Y or N
If yes, how many in a typical week do you consume?_____
Are you Allergic to any of the following?

Dental anesthetics.....Y or N
Sulfa Drugs.....Y or N
Codeine.....Y or N
Erythomycin.....Y or N
Jewelry or metals.....Y or N
Aspirin.....Y or N
Penicillin.....Y or N
Latex.....Y or N
Tetracycline.....Y or N
Other_____

(ladies only)

Are you pregnant? Y or N
Number of weeks_____
Nursing? Y or N

Taking birth control pills? Y or N
Hormone replacement? Y or N

Please circle if you have any of the following:

Abnormal Bleeding
Angina
Arteriosclerosis
Arthritis
Autoimmune Disease
Blood Transfusion
Cancer; Type_____
Cardiovascular Disease
Chest Pains
Congestive Heart Failure
Chronic Bronchitis
Chronic Pain
Congenital Heart Defects
Damaged Heart Valves
Diabetes, Type_____
Eating Disorders
Emphysema
Epilepsy
Fainting Spells
Gastro Intestinal Disease
GERD
Heart Attack
Heart Murmur
Hemophilia
Hepatitis, Type_____
Jaundice
High Blood Pressure
Other_____

HIV
Kidney Disease
Liver Disease
Low Blood Pressure
Lupus
Malnutrition
Mental Health Disorders
Mitral Valve Prolapse
Neurological Disorders
Night Sweats
Osteoporosis
Pacemaker
Persistent Swollen Glands
Recurrent Infections
Rheumatic Fever
Rheumatic Heart Disease
Rheumatoid Arthritis
Severe Headaches
Sinus Problems
Sleep Disorders
STD
Stroke
Thyroid Problems
TMJ
Tuberculosis
Ulcers

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

I understand that this office does not accept insurance for payment. I understand that I am responsible for payment of services rendered at the time of service for all costs associated with my dental treatment.

I hereby authorize release of any information including diagnosis,x-rays and records of treatment and/or examinations rendered, to my insurance company and to other dental professionals who may be involved in my care. Every effort will be made to file paperwork for the patient to receive a timely refund from the patient's insurance company.

_____ _____

Signature Date

Gregory Rutherford, DDS, PA

Consent For Treatment ,Payment & Healthcare Operations

Gregory Rutherford, DDS 3300 S Tamiami Trail, Sarasota FL 34239
941-365-5235

I consent to the use or disclosure of my protected health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care. I understand that diagnosis or treatment of me may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is required to agree to the restrictions that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent in writing at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review the above named organization's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The notice describes to me the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the above organization. The Notice of Privacy Practices are available on the above named organization's website if applicable.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of patient or representative | Printed name of patient or representative

_____ _____

Date | Description of representative's authority