



TRINITY DENTAL CLINIC Medical History Form

Date: _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBERS _____ PHYSICIAN _____

DO WE HAVE PERMISSION TO LEAVE A MESSAGE AT THE PHONE NUMBERS LISTED ABOVE?

YES _____ NO _____

IN THE EVENT OF EMERGENCY, CALL _____

PHONE _____

I GIVE PERMISSION FOR RELEASE OF DENTAL RECORDS TO:

Are you in good health?	YES	NO
Have there been any changes in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Date of your last physical exam:		
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery of any type or been hospitalized for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or have you ever taken medications to treat Osteoporosis or Padgett's disease, such as Fosamax, Actonel, Skelid, Boniva, Didronel, or Aredia?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or have you ever taken medications to treat bone cancers or bone diseases such as Aredia or Zometa?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medicine(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>
Please list ALL medications you are currently taking:		

	YES	NO
Are you allergic to or have you had a reaction to: Local anesthetics like Novocain? Aspirin? List ALL medications you are allergic to:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had any abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recent weight loss?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco? Chew? Smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol, cocaine, or any other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had the following:		
Rheumatic heart disease or rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>
Heart defect or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attack, angina?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in your chest upon exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever short of breath after mild exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever get short of breath when you lie down?	<input type="checkbox"/>	<input type="checkbox"/>
Do you require extra pillows when you sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice, or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Radiation or Chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, fainting spells or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infections?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or Rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement or implant?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Please list any disease, condition, or problem not listed above:		

All of the above is true to the best of my knowledge. I grant permission for Trinity to request/release any information including x-rays to/from other providers as necessary regarding my treatment.

PRINT PATIENT'S NAME _____

SIGN NAME _____ DATE _____

PATIENT CONSENT FOR TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care and treatment by Trinity Health Ministries, through its individual dentists, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the dentist and provided by Trinity Health Ministries.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the dentist or Trinity Health Ministries.

I acknowledge that I have received a Copy of Trinity Health Ministries' Notice of Privacy Practices and I understand that the notice is also available at the location where services are provided.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Trinity Health Ministries. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested.

I HAVE READ THIS FORM, OR HAD IT READ TO ME, AND I CERTIFY THAT I FULLY UNDERSTAND AND ACCEPT ITS CONENTS UNLESS NOTED.

PRINT PATIENT'S NAME _____ DATE _____

PATIENT'S SIGNATURE _____

WITNESS: _____



TRINITY DENTAL CLINIC
1127 East Lamar Alexander Parkway
Maryville, TN 37804

PATIENT WAIVER

Trinity Health Ministries, Inc. (THM) is a non-profit organization and is NOT part of a government program. THM focuses on urgent and emergent care for adults (age 21 and over) in Blount County Tennessee who satisfy THM's financial eligibility criteria. THM performs x-ray facilitated dental exams and informs patients of treatment options, extractions (including surgical extractions), aveoplasties (ridge trims to facilitate denture wear), oral biopsies, incision and drainage (when needed to manage oral infections), and dental prophylaxis (cleanings). Due to THM's limited opening hours, emergencies requiring treatment on non-clinic days will require treatment at alternative facilities, such as a private dental office, emergency room, or physician's office at the patient's expense.

In consideration of benevolent services that I receive at THM, I and anyone entitled to claim through me, do hereby waive and release THM or any persons or organizations acting on their behalf, from all claims of liability arising out of my acceptance of such benevolent care.

PRINT PATIENT'S NAME _____ **DATE** _____

PATIENT'S SIGNATURE _____



TRINITY DENTAL CLINIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Read the following statement:

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about the right to change our privacy practices as described in our Notice of Privacy Practices. A copy of our Notices of Privacy Practices accompanies this Consent. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I have received a copy of this office’s Notice of Privacy Practices.

I attempted to obtain written acknowledgement of receipt of Notice of Private Practices, but acknowledgement could not be obtained.

Reason: _____

SIGNATURE: _____ **DATE:** _____

At any time you have the right to revoke consent to disclose your healthcare information.