wesley Health Centers | Dental & Oral Health Care

Wesley Health Centers Dental Clinics
Health Questionnaire

Name: _____ Date: ____/____/____

Address: _____

Tel: _____ Cell: _____ SSN: ____/____/____

MEDICAL HISTORY

(Please indicate if you have a past or present history of the following medical conditions)

AIDS/HIV+	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No
Aizheimer's	☐ Yes	☐ No	Fainting spells	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Frequent headaches	☐ Yes	☐ No	Pain in jaw joint	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Parathyroid disease	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No	Heart attack	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Renal dialysis	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	Heart surgery	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Bruise easily	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Scarlet fever	☐ Yes	☐ No
Candidiasis	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
CMV Infection	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Sickle cell disease	☐ Yes	☐ No
Cold sores	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
Congenital heart	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Spina bifida	☐ Yes	☐ No
Cortisone	☐ Yes	☐ No	Irregular heart beat	☐ Yes	☐ No	Stomach trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Drug abuse	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Tumors or growths	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Excessive bleeding	☐ Yes	☐ No	Lung disease	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No	COVID-19	☐ Yes	☐ No

Are you allergic to any of the following?

Aspirin ☐ Penicilin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics ☐
Sulfa ☐ Other ☐ No allergies ☐

If yes, please explain: _____

Questions for women only:

Pregnant / Trying to get pregnant? ☐ Yes ☐ No
Taking oral contraceptives? ☐ Yes ☐ No
Nursing? Yes No

Have you ever had a serious illness not listed above? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you vape? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Have you ever given yourself an injection? ☐ Yes ☐ No
Are you taking any medications at this time? ☐ Yes ☐ No
If yes, please explain:

If yes, please explain:
_____
_____
_____

_____

Name of Medical Doctor: _____ Date of last visit? _____

Address: _____ Tel: _____

Dental history:

Do you need to be pre-medicated with antibiotics before dental treatement? ☐ Yes ☐ No
Are you in dental pain? ☐ Yes ☐ No
Do you have pain in your jaw? ☐ Yes ☐ No
Have you ever had a serious problem with dental treatment? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
Do you grind your teeth at night? ☐ Yes ☐ No
Have you ever had oral surgery? ☐ Yes ☐ No
Does going to the dentist make you anxious? ☐ Yes ☐ No ☐ A little ☐ A lot ☐ Extremely
Describe your current dental health? ☐ Good ☐ Fair ☐ Poor

Medical & Dental History Reviewed By (*Dentist's Name*): _____ Date: _____

Emergency contact:

In the event of an emergency, who can we contact?

Name: _____ Relationship: _____
Tel: _____

Consent for treatment:

By signing this form I attest that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsability to inform this office of any changes to my medical history. I hereby grant authority to the dentists and auxiliary staff of the Wesley Health Centers Dental Clinics to administer dental treatment; to administer the necessary anesthetics and analgesics; and to perform the appropriate operations that are deemed necessary or advisable in the diagnosis and treatment of the following patient.

Print name: _____ Date: _____

Signature: _____

wesley Health Centers

Dental & Oral Health Care

Dental History:

Name: _____ Date of birth: _____ / _____ / _____
(First name | *Nombre*) (Middle initial | *Inicial*) (Last name | *Apellido*) *Fecha de Naciemiento*

Who referred you to the dental clinic?
Quién lo refirió a la clínica dental? _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Poor
Actualmente su salud dental está? ☐ *Excelente* ☐ *Buena* ☐ *Mala*

Date of most recent Dental Exam? | *Fecha de último Examen Dental?* _____ / _____ / _____

I routinely see my Dentist every:
Visito a mi Dentista cada? ☐ 3mos/*meses* ☐ 6mos/*meses* ☐ 12mos/*meses*

What is the primary reason for your visit?
Cúal es la razón principal de su vista? _____

Are you currently in pain? | *Actualmente tiene dolor?* ☐ Yes/*Si* ☐ No/*No*

If yes, how bad is your pain on a scale of 1-10 with 10 being worse?
Si contestó sí, usando una escala de 1 a 10 (10 siendo lo peor), cúanto le duele? _____

Do you require antibiotics before dental treatment?
Necesita antibióticos antes de su tratamiento dental? ☐ Yes/*Si* ☐ No/*No*

Personal History:

1. Are you fearful of dental treatment? | *Tiene miedo a su tratamiento dental?* ☐ Yes/*Si* ☐ No/*No*
   If yes, how fearful on a scale of 1 (least) to 10 (most)?
   Si contestó sí, usando una escala de 1 a 10 (10 siendo lo más), cúanto miedo tiene? _____
2. Have you ever had complications from past dental treatment?
   Alguna vez ha tenido complicaciones asociadas con tratamientos dentales? ☐ Yes/*Si* ☐ No/*No*
3. Have you ever had trouble getting numb?
   Alguna vez ha tenido problemas siendo anestesiado? ☐ Yes/*Si* ☐ No/*No*
4. Have you ever had a bad reaction to dental anesthetics?
   Alguna vez ha tenido una mala reacción a los anestésicos dentales? ☐ Yes/*Si* ☐ No/*No*
5. Did you ever have braces, orthodontic treatment?
   Alguna vez ha tenido ortodoncia/frenos? ☐ Yes/*Si* ☐ No/*No*
6. Did you ever have any teeth removed?
   Alguna vez ha tenido extraciones dentales? ☐ Yes/*Si* ☐ No/*No*
7. How many times/day do you brush your teeth?
   Cuántas veces al día se cepilla los dientes? ☐ Never / *Nunca* ☐ 1X ☐ 2X
8. How many times/day do you floss?
   Cuántas veces al día usa seda/hilo dental? ☐ Never / *Nunca* ☐ 1X ☐ 2X

Smile Characteristics:

9. Is there anything about the appearance of your teeth that you would like to change, if so what?
Hay algo que le gustaría cambiar de su sonrisa, si la respuesta es sí, qué sería? _____

_____

10. Have you ever whitened or bleached your teeth?
Alguna vez ha blanqueado sus dientes? ☐ Yes/*Si* ☐ No/*No*

11. Have you ever had any of the following dental conditions? (Please circle Yes or No)
Ha tenido los siguientes problemas dentales? (Por favor marque Si ó No)

Bleeding gums | *Sangrado de encías*	☐ Yes | *Si* ☐ No | *No*	Mobility of teeth | *Movilidad*	☐ Yes | *Si* ☐ No | *No*
Bad taste | *Mal sabor de boca*	☐ Yes | *Si* ☐ No | *No*	Oral cancer/biopsy | *Cancer oral*	☐ Yes | *Si* ☐ No | *No*
Bad odor | *Mal olor de boca*	☐ Yes | *Si* ☐ No | *No*	Osseous surgery | *Cirugía oral*	☐ Yes | *Si* ☐ No | *No*
Cold sores | *Ulceras en la boca*	☐ Yes | *Si* ☐ No | *No*	TMJ/TMD Joint Pain	
Deep cleaning | *Limpieza profunda*	☐ Yes | *Si* ☐ No | *No*	*Dolores en articulaciones*	☐ Yes | *Si* ☐ No | *No*
Gum disease | *Enfermedad de encías*	☐ Yes | *Si* ☐ No | *No*	Toothbrush abrasion | *Abración*	☐ Yes | *Si* ☐ No | *No*
Hot sensitivity | *Sensibilidad al calor*	☐ Yes | *Si* ☐ No | *No*	Extractions | *Extracciones*	☐ Yes | *Si* ☐ No | *No*
Cold sensitivity | *Sensibilidad al frío*	☐ Yes | *Si* ☐ No | *No*	Dentures | *Dentaduras*	☐ Yes | *Si* ☐ No | *No*
Chewing pain | *Dolor al masticar*	☐ Yes | *Si* ☐ No | *No*	Cavities | *Caries*	☐ Yes | *Si* ☐ No | *No*
Grind teeth | *Rechinar los dientes*	☐ Yes | *Si* ☐ No | *No*	Dry mouth | *Boca seca*	☐ Yes | *Si* ☐ No | *No*
Worn an occlusal guard		Gum recession | *Recesión de encías*	☐ Yes | *Si* ☐ No | *No*
Ha usado alguna guarda ó protector	☐ Yes | *Si* ☐ No | *No*	Family history of gum disease	
		Familiares con enfermedad de encías	☐ Yes | *Si* ☐ No | *No*

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical or dental status.

Entiendo que la información que he dado hoy es correcta y exacta basada en mi concocimiento. También entiendo que esta información será mantenida en estricta privacidad y es mi responsabilidad informar a esta oficina si algún cambio ocurre con mi condición medica ó dental.

Patient | Parent or Guardian Signature: _____ Date: _____
Firma del Paciente Fecha

Dental provider comments | Notes: _____

_____

_____

I verbally reviewed the medical/dental information with the patient (parent) named herein.
Dental provider signature: _____ Date: _____

Health history update:

Date:	Changes to Health History:	Patient | Parent Signature:	Dental Provider Signature:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

wesley Health Centers | Dental & Oral Health Care

BROKEN APPOINTMENT/NO SHOW/LATE TO APPOINTMENT POLICY

Dear Patient/Parent,

Thank you for choosing Wesley Health Centers for your dental health care needs. We are committed to providing the best possible experience for our dental patients and making every effort to accommodate schedules when booking follow up appointments. There are times when demand for our services is greater than our capacity to provide care.

Broken Appointments/No Show: (Please initial each line below)

_____ Patients are only allowed 2 broken appointments in a 6 month time period.

_____ Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.

_____ Late cancellations are considered broken appointments. If you need to cancel your appointment, we ask that you please call us at least 24 hours before your appointment time. Any cancellations with less than 24 hours' notice will be considered a "Broken Appointment".

_____ Late arrivals are also considered broken appointments. If you do not arrive by 15 minutes after the start time of your appointment, the dental team will make every effort to accommodate you as quickly as possible. However, the planned treatment may be changed. You may be offered a different appointment time in the same day, and the wait time in the clinic may be extended. If you are more than 30 minutes late, your appointment may be rescheduled to a different day.

Appointment Confirmation: Our front office staff will call to confirm your appointment 48 hours in advance. If we cannot contact you, a voice message will be left. If for any reason, a patient misses their appointment or cancels late for a second time within a 6-month period, they will not be scheduled for another appointment, but placed on a waiting list. However, you are still welcome to receive emergency dental care from us. Patients who have 2 broken appointments with us can: 1) call us in the mornings for a "same day appointment" to see if we have an opening, 2) ask to be placed on a "same day call list", or 3) if experiencing a dental emergency such as pain or swelling, ask to be seen as an emergency patient or "walk-in" to the clinic. We always do our best to work our walk-in emergency patients into the schedule.

Many patients use Wesley Health Centers dental services. Your help in keeping your appointments enables us to provide better and timelier care to all of our patients.

_____ _____

Patient or Parent/Guardian Signature Date

wesley Health Centers | Dental & Oral Health Care

PATIENT ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

Please sign and date below to indicate that you have received a copy of this notice. Your signature simply acknowledges that you have received a copy of this notice. I, acknowledge that I have received from the John Wesley Health Center a copy of the Dental Materials Fact Sheet dated.

_____

Patient's Name (Last, Frist, Middle Initial)

_____ _____

Signature Date

10- ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES & CLIENT GRIEVANCES PROCEDURE

I, _____ , do hereby acknowledge receipt of the following documents:

1. Notice of HIPAA Practices, Policies and Procedures
2. Client Grievances Procedure

_____ _____

Patient's Name Date

_____

Patient's Signature