Health History Form

Are you in pain today? **Yes** ☐ No ☐ Today's Date: ______________________

Last Name: ______________________________ First Name ________________________________ Middle_________

Date of birth: _____-_____-___________ Sex: M / F SS # _______-_____-_______ Height: _______ Weight: ______lbs.

Address: ____City: ________________ State: ____Zip: _______

Occupation: ____________________________Work Phone: (_____)______-_________Home Phone: (_____)______-_________

Cell Phone: (_____)______-_________ Can we send text messages ? Yes ☐ No☐ Email: _____________________________

Emergency Contact: __________________ Relationship: ______________________ Cell Phone: (_____)______-_________

If you are completing this form for another person, what is your relationship to that person?

Your Name: ______________________________________Relationship: ____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)

	Yes	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Cough that produces blood	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions. Yes No DK

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? ______________________			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Have you had any complications with previous treatment?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐

Date of your last dental exam: ___________________ What was done at that time?: ____________________________________

Date of last dental x-rays: ___________________ What is the reason for your dental visit today: ________________________________

How do you feel about your smile?, would you like to change anything ?: ____

____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Are you now under the care of a physician? Yes ☐ No ☐

Date of last physical exam: _____________ Physician Name: ____________________________________

Address / City / State / Zip: ____ Phone: (_____) ______-_________

Are you in good health? Has there been any change in your general health within the past year? Yes ☐ No ☐

If yes, what condition is being treated?

____

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

If yes, what was the illness or problem?

____

Are you taking or have you recently taken any prescription or over the counter medicines? Yes ☐ No ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

____
____
____
____
____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Joint Replacement - Have you had an orthopedic total joint (hip, knee, elbow, finger replacement? Yes □ No □
Date: ____________ If yes, have you had any complications? ______________________________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? Yes □ No □
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes □ No □
Date Treatment began: ___________________________________

Allergies - Are you allergic to or have you had a reaction to (to all yes responses, specify reaction):

Local anesthetics Yes □ No □
Penicillin Yes □ No □
Sulfa drugs Yes □ No □
Hay fever or other seasonal allergies Yes □ No □
Metals Yes □ No □
Food Yes □ No □
Aspirin Yes □ No □
Barbiturates, sedatives or sleeping pills Yes □ No □
Codeine or other narcotics Yes □ No □
Latex Yes □ No □
Other allergies: Yes □ No □
Other allergy: _____________________________________

Do you use tobacco (smoking, snuff, chew, bidis)?
If so, how interested are you in stopping? Yes □ No □
(Circle one) VERY / SOMEWHAT / NOT INTERESTED
Do you use controlled substances Yes □ No □
If yes, how much in the last 24 hours? _____________
Do you drink alcoholic beverages? Yes □ No □
If yes, how much do you typically drink in a week? ________________

WOMEN ONLY – Are You:

Pregnant? Yes □ No □ Number of weeks: ______________
Taking birth control pills or hormonal replacement? Yes □ No □ Nursing? Yes □ No □

Do You have any of the following diseases or problems:

Artificial (prothetic) heart valve Yes □ No □
Damaged valves in transplanted heart Yes □ No □
Unrepaired, cyanotic CHD Yes □ No □
Repaired CHD with residual defects Yes □ No □
Previous infective endocarditis Yes □ No □
Congenital heart disease (CHD) Yes □ No □
Repaired (completely) in last 6 months Yes □ No □

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Autoimmune disease Yes □ No □
Systemic lupus erythematosus Yes □ No □
Bronchitis Yes □ No □
Chest pain upon exertion Yes □ No □
Malnutrition Yes □ No □
Night sweats Yes □ No □
Gastrointestinal disease Yes □ No □
Heartburn Yes □ No □
Osteoporosis Yes □ No □
Cardiovascular disease Yes □ No □
Congestive heart failure Yes □ No □
Angina Yes □ No □
Damaged heart valves Yes □ No □
Mitral valve prolapse Yes □ No □
Arthritis Yes □ No □
Persistent swollen glands in neck Yes □ No □
Rheumatic heart disease Yes □ No □
Sexually transmitted disease Yes □ No □
Hepatitis, jaundice or liver disease Yes □ No □
Abnormal bleeding Yes □ No □

Rheumatoid arthritis Yes □ No □
Asthma Yes □ No □
Emphysema Yes □ No □
Chronic pain Yes □ No □
Epilepsy Yes □ No □
Kidney problems Yes □ No □
Sleep disorder Yes □ No □
Severe headaches Yes □ No □
Ulcers Yes □ No □
Arteriosclerosis Yes □ No □
Anemia Yes □ No □
Low blood pressure Yes □ No □
Heart Attack Yes □ No □
Pacemaker Yes □ No □
Stroke Yes □ No □
AIDS HIV infection Yes □ No □
Cancer Yes □ No □
Recurring infections Yes □ No □
Mental health disorders Yes □ No □ Specify: ______________________
If yes, date: _____________________

Sinus trouble Yes □ No □
Tuberculosis Yes □ No □
Diabetes Yes □ No □
Eating disorder Yes □ No □
G.E. Reflux Yes □ No □
Kidney problems Yes □ No □
Excessive urination Yes □ No □
Rapid weight loss Yes □ No □
Thyroid problems Yes □ No □
Hemophilia Yes □ No □
Blood transfusion Yes □ No □
High blood pressure Yes □ No □
Heart murmur Yes □ No □
Rheumatic Fever Yes □ No □
Glaucoma Yes □ No □
Ulcers Yes □ No □
Chemo/Radiation Therapy Yes □ No □
Specify: ______________________

Fainting spells or seizures Neurological disorders Yes □ No □ Specify: ______________________
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes □ No □
Name of physician or dentist making recommendation: ______________________________________ Phone: ____________________
Do you have any disease, condition or problem not listed above that you think I should know about? Yes □ No □
Please explain:
____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: ____ Date: ____________________

FOR COMPLETION BY DENTIST
Comments:
____
____

Insurance Information

Name of responsible Party: ______________________ Relationship to patient: _________________________
Sex: M / F Date of birth: _____/_____/_______ SS# _____-____-_____ Marital Status: _____________________
Home address: ______________________________ City: ______________________ State: ______ Zip: _______________
Phone number: (____) ____-______ Work phone number: (____) ____-______ Occupation: _______________
Employer address: ____________________________ City: ______________________ State: ______ Zip: ______________

Primary insurance

Policy Holder Name : __________________________ Relationship to Patient: __________________________________
Sex: M / F Date of birth: _____/_____/_______ SS# _____-____-_____ Marital Status: ____________________
Insurance Co: __________________________________ Group #: ____________ Group name: _________________________
Policy number: __________________________________ Phone number: _____________________________
Address: _____________________________________ City: ______________________ State: ______ Zip: __________

Secondary insurance

Policy Holder Name : __________________________ Relationship to Patient: __________________________________
Sex: M / F Date of birth: _____/_____/_______ SS# _____-____-_____ Marital Status: ____________________
Insurance Co: __________________________________ Group #: ____________ Group name: _________________________
Policy number: __________________________________ Phone number: _____________________________
Address: _____________________________________ City: ______________________ State: ______ Zip: __________

FINANCIAL POLICY

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our **FINANCIAL POLICY**. If you have any questions, please ask the front desk.

1. VERIFYING INSURANCE: **As a courtesy to you,** we will verify your insurance for eligibility benefits prior to your appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. **You are ultimately responsible** for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

2. PAYMENT: Payment is due **at the time of service.** Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well. Once treatment is rendered, no refunds will be issued. If additional procedures are required during the course of treatment, the patient is responsible for the cost of additional treatment.

3. INSURANCE INFORMATION: **New insurance** as well as **changes in insurance** must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

4. CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be kept current with our office. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency.

5. REQUESTS FOR ADDITIONAL INFORMATION: These must be responded to **immediately**. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.

6. PAYMENT PLANS and 3rd PARTY FINANCING: Please see our staff at the front desk for details.

7. BALANCES: If your account balance exceeds 30 days, you will receive a notice informing you that your account is **overdue**. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a **collection fee** (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

8. RETURNED CHECKS: There will be a **$30** fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

9. CANCELLATIONS/FAILED APPOINTMENTS: We request **24-hours notice** if you are cancelling an appointment.
There will be a **$50** fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The $50 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is **paid in full**.

*** Thank you for reading this information in full. Please sign below to acknowledge your understanding of the entire FINANCIAL POLICY. ***

Patient or Guardian Signature ____ **Date** ___________
Patient or Guardian Name (Please Print) ____
Signature of Dentist ____ **Date** ___________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA), provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Service. www.hhs.gov
We have adopted the following policies:
1. Patient information will be kept confidential except as is necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for our care. Patient records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, text messaging, e-mail, U.S. mail or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

WORK TO BE DONE

I understand that I am having the following work done (X) photos (X) x-rays (X) exam (X) cleaning (X) fluoride

SEALANTS: I understand that I may receive sealants. Sealants are a protective coating material that is applied to the chewing surface of back molars to act as a protective barrier from acids and plaque. Sealants generally last for several years but occasionally require reapplication.

DRUGS AND MEDICATIONS: I understand that local anesthetics, antibiotics, pain medications and other drugs can cause redness, swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I understand that not everyone reacts the same to medication and such reactions are not predictable.

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures, a crown being required instead of a routing filling and an extraction being required due to a non-restorable tooth with gross decay or fracture. If this is the case, proposed changes will be explained to me. Any differences in fee will be authorized by me before any changes take place.

FILLINGS: I understand that teeth can become or remain sensitive after having a filling placed. This can occur with either amalgam (silver) or composite (tooth colored) filling materials. Sensitivity may require additional treatment. Removal of deep decay can lead to an abscessed tooth requiring either a root canal or extraction. I understand that if I need additional treatment the cost is my responsibility.

I understand that dentistry is not an exact science and that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. All of my questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient Name: ____
Signature of Patient ____ **Date** ____________
Signature of Parent/Guardian (if patient is a minor) ____________________________ **Date** ____________
Signature of Dentist ____ **Date** ____________
Signature of Witness ____ **Date** ____________