



# Welcome to Our Office!

Mr. \_\_\_\_\_ Date \_\_\_\_\_  
Mrs. \_\_\_\_\_  
Ms. \_\_\_\_\_  
Dr. \_\_\_\_\_ Last First Middle

Home Address \_\_\_\_\_  
Street No. Apt. # City State Zip

Birth Date \_\_\_\_\_ Phone \_\_\_\_\_ SS# \_\_\_\_\_

E-mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Reason for Visit to Our Office \_\_\_\_\_

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Person or Guardian Responsible for Paying Your Bills \_\_\_\_\_

Address of Responsible Party \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Birth date \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Spouse SS # \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

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Who referred you to our office? \_\_\_\_\_

Name of Family Physician \_\_\_\_\_

Has any member of your immediate family been in this office before? \_\_\_\_\_

Who? \_\_\_\_\_ Approximate Date \_\_\_\_\_

Nearest Relative, other than above, to notify in case of an emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

# Health History Form

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Dr. \_\_\_\_\_

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

Your Name \_\_\_\_\_ Relationship \_\_\_\_\_

Date of your last dental exam \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

What was done at that time? \_\_\_\_\_

How would you describe your current dental problem? \_\_\_\_\_

**For the following questions, please circle whichever applies. Your answers are for our record only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.**

## Dental Information

**Yes No Don't  
Know**

- |   |   |   |   |
|---|---|---|---|
| Y | N | ? | Do you feel you may have bad breath at times?               |
| Y | N | ? | Do your gums bleed when you brush?                          |
| Y | N | ? | Are your teeth sensitive to cold, hot, sweets or pressure?  |
| Y | N | ? | Have you had any periodontal (gum) treatments?              |
| Y | N | ? | Do you occasionally have an unpleasant taste in your mouth? |
| Y | N | ? | Have you ever had orthodontic (braces) treatment?           |
| Y | N | ? | Do you have headaches, earaches or neck pains?              |
| Y | N | ? | Do you wear removable dental appliances?                    |

If you could change anything about your mouth, teeth, or smile, what would that be?

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Yes No Don't Know**

Y N ? Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? \_\_\_\_\_

Y N ? Have you had any complications or difficulties with your prosthetic joint?

Y N ? Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose? \_\_\_\_\_

Name of Physician or Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**NOTE TO PATIENT-** A report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopedics Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints (> 2 years). This office will be glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

**Yes No Don't Know**

Y N ? Have you had a serious/difficult problem associated with any previous dental treatment? \_\_\_\_\_

Y N ? Are you in good health?

Y N ? Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: If yes **STOP** filling out the form and return this form to the receptionist.

Y N ? Active Tuberculosis

Y N ? Persistent cough for more than a three-week duration

Y N ? Cough that produces blood

Y N ? Are you now under the care of a physician? If so, what is/are the condition(s) being treated? \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Physician(s) \_\_\_\_\_ Phone \_\_\_\_\_

Y N ? Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? \_\_\_\_\_

Y N ? Are you taking, or have you recently taken, any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?

Prescribed \_\_\_\_\_

Over the counter \_\_\_\_\_

Natural or herbal preparations \_\_\_\_\_

**Are you allergic to or have you had a reaction to:**

**Yes No Don't Know**

Y N ? Local anesthetics

Y N ? Latex

Y N ? Aspirin

Y N ? Iodine

Y N ? Penicillin or other Antibiotics

Y N ? Hay fever/seasonal

Y N ? Barbiturates, sedatives, or sleeping pills

Y N ? Animals

Y N ? Sulfa drugs

Y N ? Food (Specify) \_\_\_\_\_

Y N ? Codeine or other narcotics

Y N ? Other.(Specify) \_\_\_\_\_

To yes responses -specify type of reaction:

**Please circle if you have or had any of the following diseases, or problems: Name \_\_\_\_\_**

Y N ? Abnormal bleeding	Y N ? GI reflux
Y N ? AIDS or HIV	Y N ? Glaucoma
Y N ? Anemia	Y N ? Hemophilia
Y N ? Arthritis	Y N ? Hepatitis, Jaundice, Or Liver Disease
Y N ? Rheumatoid arthritis	Y N ? Recurrent Infections, Type _____
Y N ? Asthma	Y N ? Kidney Problems
Y N ? Blood transfusion	Y N ? Low Blood Pressure
If yes, date _____	Y N ? Mental Health Disorders
Y N ? Cancer/Chemotherapy/Radiation Treatment	If Yes, Specify _____
Y N ? Cardiovascular disease	_____
If yes, specify below	Y N ? Malnutrition
Angina	Y N ? Migraines
Arteriosclerosis	Y N ? Night sweats
Artificial heart valve	Y N ? Neurological disorders
Coronary insufficiency	If yes, specify _____
Coronary occlusion	Y N ? Osteoporosis
Damaged heart valves	Y N ? Persistent swollen glands in neck
Heart attack	Y N ? Respiratory problems
Heart murmur	If yes, specify
High blood pressure	Emphysema
Inborn heart defects	Bronchitis
Mitral valve prolapse	Y N ? Severe headaches
Pacemaker	Y N ? Rapid weight Loss or Gain
Rheumatic heart disease	Y N ? Sexually transmitted disease
Chest pain upon exertion	Y N ? Sinus trouble
Chronic pain	Y N ? Sleep disorder
Y N ? Persistent diarrhea	Y N ? Sores or ulcers in the mouth
Y N ? Disease, Drug or radiation induced immunosuppression	Y N ? Stroke
Y N ? Diabetes	Y N ? Systemic lupus erythematosus
If yes, specify	Y N ? Thyroid problems
Type I (insulin dependent)	Y N ? Ulcers
Type II	Y N ? Excessive urination
Y N ? Dry mouth	Y N ? Do you have any disease, condition or problem not listed above that you think I should know about? Please explain _____
Y N ? Eating disorder	_____
If yes, specify _____	_____
Y N ? Epilepsy	_____
Y N ? Excessive thirst	_____
Y N ? Fainting spells	_____

Y N ? Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (desphenfluramine) or phen-fen (phentermine)?

Y N ? Do you drink bottled or filtered water on a regular basis?

Y N ? Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_ in the past month? \_\_\_\_\_ If yes, \_\_\_\_\_ # of drinks per day for \_\_\_\_\_ years

Y N ? Are you alcohol and/or drug dependent? If so, have you received treatment? Yes No. Do you use drugs or other substances for recreational purposes? If yes, please list: \_\_\_\_\_

Frequency of use (daily, weekly, etc.) \_\_\_\_\_ Number of years of use \_\_\_\_\_

Y N ? Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Circle one) Very Somewhat Not interested

Y N ? Do you wear contact lenses?

**Women Only**

Y N ? Are you pregnant?

Y N ? Nursing?

Y N ? Taking birth control pills?



## Consent for Services

I hereby certify that I have read and understand the information above, and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

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Signature of patient, parent, or guardian:

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Date