Welcome to Our Office!

Mr.
Mrs.
Ms. _____ Date _____
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 _____

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 _____

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?

_____

_____

_____

_____

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 _____

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 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		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
			Barbiturates, sedatives, or sleeping	Y	N	?	Animals
Y	N	?	pills	Y	N	?	Food (Specify) _____
Y	N	?	Sulfa drugs	Y	N	?	Other. (Specify) _____
Y	N	?	Codeine or other narcotics				

To yes responses -specify type of reaction:

_____

_____

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

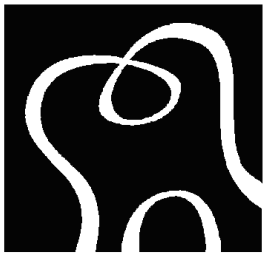
Y N ? Abnormal bleeding
Y N ? AIDS or HIV
Y N ? Anemia
Y N ? Arthritis
Y N ? Rheumatoid arthritis
Y N ? Asthma
Y N ? Blood transfusion
If yes, date_____
Y N ? Cancer/Chemotherapy/Radiation Treatment
Y N ? Cardiovascular disease
If yes, specify below
Angina
Arteriosclerosis
Artificial heart valve
Coronary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

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 your received treatment? Yes No.
Y N ? 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 Service



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, payers, 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.

_____ _____

Signature of patient, parent, or guardian: Date