Health History Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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.

Name: Last First Middle
Home Phone: Include area code ( )
Business/Cell Phone: Include area code ( )

Address: Mailing address
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: Include area code ( ) Cell Phone: Include area code ( )

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 the question)

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
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?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

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?

Medical Information

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

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

Physician Name: Phone: Include area code ( )

Address/City/State/Zip:

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

If yes, what condition is being treated?

Date of last physical exam:

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

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

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

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Medical Information

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

(Check DK if you Don't Know the answer to the question)

Question	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ____ If yes, have you had any complications? ____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ____			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? Circle one: VERY / SOMEWHA T / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ____			
If yes, how much do you typically drink i n a week? ____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: ____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all yes responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics ____	☐	☐	☐
Aspirin ____	☐	☐	☐
Penicillin or other antibiotics ____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____	☐	☐	☐
Sulfa drugs ____	☐	☐	☐
Codeine or other narcotics ____	☐	☐	☐
Metals ____	☐	☐	☐
Latex (rubber) ____	☐	☐	☐
Iodine ____	☐	☐	☐
Hay fever/seasonal ____	☐	☐	☐
Animals ____	☐	☐	☐
Food ____	☐	☐	☐
Other ____	☐	☐	☐

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

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

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

Condition	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ____			
Recurrent Infections	☐	☐	☐
Type of infection: ____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Question	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: Include area code
( )

Question	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

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:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

FINANCIAL POLICY

We are proud to be a part of the team whose primary mission is to deliver you the finest and most comprehensive dental care available today. In addition, we are dedicated to making your top-quality care as cost effective as possible. To promote a long-term satisfying relationship, we have laid out our office financial policies below.

PAYMENT OPTIONS

- For all patients, payment liability for service is due at, or prior to the time services are rendered.
- For patients with insurance, we will collect any deductible and/or estimated co-payment at the time of service.
- We accept cash, check, Visa, MasterCard, Discover and American Express; we also offer financing through Care Credit and Lending Club.
- Any patient liability owed from previous treatment will be subject to payment plan contingent upon allowing our clinic to hold a credit card on file.

INSURANCE: As a courtesy to you, we will file a claim for payment with your insurance company.

- We will gladly discuss your proposed treatment, answer any questions related to your insurance and provide you with an **ESTIMATE** of what your insurance company will pay towards your treatment.
- Our office makes no guarantee of the actual payment by your insurance company, which may differ from the original estimate.
- Not all services we provide are covered benefits by insurance. Fees for non-covered services are due at, or prior to time of service.
- Your insurance is a contract between you, your employer and your insurance company; you are FULLY RESPONSIBLE for any charges for the treatment rendered and any differences between the original estimate and final bill.
- We will bill your secondary insurance as a courtesy but you are responsible for the estimated out of pocket related to the primary insurance.
- We do not bill medical insurances for services rendered at our clinic.

MISSED APPOINTMENTS

- For general dentistry appointments, a fee of $50 will be charged for all missed and short notice (less than 24-hour notice) cancelled appointments.
- For specialty appointments, a fee of $150 will be charged for all missed and short notice cancellations.
- Our office reserves the right to limit future appointments if short notice cancellations occur more than twice. Appointments are made on a per need basis and this time is reserved exclusively for you and your dental needs.

RETURNED CHECKS: A $25 charge will be applied when a check is returned from the bank

DENIED CREDIT CARD: A $25 charge will be applied when a credit card is denied when patient is on a payment plan

Primary Insurance Information:

Insurance Company: ___________________________________ Subscriber Name: _________________________________

Subscriber's DOB: ____________ Relationship: _________________ ID#: ______________ Group#: _________________

Secondary Insurance Information:

Insurance Company: ___________________________________ Subscriber Name: _________________________________

Subscriber's DOB: ____________ Relationship: _________________ ID#: ______________ Group#: _________________

Your signature below acknowledges that you received this form and you fully understand all of our policies.

Signature ____ Date ___________________