HEALTH HISTORY

Patient Name:_____________________________________ Birth Date:_________________

I. CIRCLE APPROPRIATE ANSWER :

1.Yes No Is your general health good? If NO, why?____

2.Yes No Has there been a change in your health within the last year?

3.Yes No Hospitalized or had a serious illness in the last three years? If YES, why?______________________

4.Yes No Are you being treated by a physician now? The Reason?
Mo/Yr of last medical exam:__________ Mo/Yr of last Dental exam:____________

5.Yes No Have you had problems with prior dental treatment? What were they?_________________________

6.Yes No Are you in pain now? Where?____

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Shortness of breath?
9. Yes No Bleeding problems, bruising easily
10. Yes No Sinus problems?
11. Yes No Frequent vomiting, nausea?
12. Yes No Dizziness?
13. Yes No Migraine headaches?
14. Yes No Fainting spells?
15. Yes No Seizures?
16. Yes No Dry mouth?
17. Yes No Joint pain, stiffness?
If YES, which joints: _______________

III. DO YOU HAVE OR HAVE YOU HAD:

18. Yes No Heart disease?
19. Yes No Heart attack? Dates:____________________
20. Yes No Heart defects or murmurs?
21. Yes No Diabetes? Type I or II?
22. Yes No Stroke? Dates:____________
23. Yes No High blood pressure?
24. Yes No Asthma, TB, emphysema, lung diseases?
25. Yes No Stomach problems, ulcers?
26. Yes No Osteoporosis
27. Yes No Anemia?
28. Yes No Tumors/cancer? Type:
29. Yes No Arthritis, rheumatism?
30. Yes No HIV/AIDS?
31. Yes No VD (syphilis, gonorrhea)?
32. Yes No Herpes (oral or genital)?
33. Yes No Kidney, bladder disease?
34. Yes No Thyroid, adrenal disease?
35. Yes No Hepatitis, liver disease?

Please list any mental health or behavioral issues (dementia, Alzheimer's, learning disability, developmental delay,ADHD):

____

IV. DO YOU HAVE OR HAVE YOU HAD:

36. Yes No Psychiatric care (bipolar, depression)?
37. Yes No Pacemaker?
38. Yes No Prosthetic heart valve?
39. Yes No Artificial joint? Which?
40. Yes No Radiation treatments?
41. Yes No Chemotherapy?
42. Yes No Blood transfusions?

V. Medications:

43. Yes No Recreational drugs? (Yes we need to know; it could be dangerous if we don't. I'll be kept confidential) :____

44. Yes No Bisphosphonates orally or by IV (Boniva, Fosamax, Reclast)?

LIST ALL MEDICATIONS and what they are for, prescriptions as well as over-the-counter and herbal:
RX: ____

____

____

Please list ALL ALLERGIES to drugs, foods, medications, latex:____________________________

VI. WOMEN ONLY:

45. Yes No Are you or could you be pregnant? Due date: 46. Yes No Are you nursing?

VII. ALL PATIENTS:

47. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:____ Date:_________________

Guardian's signature:____ Date:_________________

PATIENT REGISTRATION

Patient's Name	Sex: M F	Birthdate	Age	Today's Date
Street Address		City	State	Zip
Please Circle One: Single, Married, Separated, Widow		Occupation		**Cell Phone**
Your Employer	How Long Employed	Your Soc Sec. #		Home Phone
Are you a full time student? •Yes • No	*If patient is minor we need:*	*Mother's Birthdate:*		*Father's Birth Date:*
Person responsible for account		Driver's license number		
Name of spouse (Parent if minor)		**E-mail address**		
Spouse's (parent's) employer	Spouse's Soc. Sec. #			Work phone
How did you hear about our office?		EMERGENCY INFORMATION		
Reason for this visit		Name, Address, & telephone of ____________________ A Relative Not living with you.		

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have a double insurance coverage, complete this for the second coverage**		
Insured's name	DOB	SS#	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	Local #		Group #	Local #	

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- **We ask that you pay any deductible and co-payment, any your patient portion, not covered by your insurance company, at the time we provide the service to you**, or before.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time**.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

PATIENT Signature (Parent of Child)______________________________ Date:______________