Confidential Health History Form

Today's Date ____________________

Patient Name: First ____________________ MI ____ Last ____________________ **Date of Birth** ____________________

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain ____________________
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain ____________________
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain ____________________
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain ____________________
   Date of last medical exam? ____________________ **Reason for exam** ____________________
5. **Yes / No** **Have you had problems with prior dental treatment?**
   If YES, explain ____________________
   Date of last dental exam ____________________ **Name of last treating dentist** ____________________
6. **Yes / No** **Are you in pain now?**
   If YES, explain ____________________

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No	AIDS/HIV	Yes / No	Anxiety	Yes / No	Depression	Yes / No	Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others ____________________

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking ______________________________

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** ______________________________
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain ______________________________
____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why ______________________________

Yes / No **Have you ever taken Fen-Phen?**
If YES, when ______________________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature ______________________________ Date ______________

Physician's Name ______________________________ Phone Number ______________

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature of Patient (Parent or Guardian) ______________ Date ______________________________ Signature of Dentist ______________ Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Patient Information Form

Today's Date ____________

Patient Name: First ____________ MI ____ Last ____________ Nickname ____________

Address: Street ____________ City ____________ State ________ Zip ________

Phone: Home ____________ Work ____________ Mobile ____________

E-mail address ____________

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number ____________ **Date of Birth** ____________

Drivers License # ____________ **State** ____________

Patient Employed By ____________ **Occupation** ____________ **Phone** ____________

Address: Street ____________ City ____________ State ________ Zip ________

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? ____________

Relationship to Patient ____________ **Home Phone** ____________ **Mobile Phone** ____________

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** ____________

Name of Responsible Party: First ____________ Last ____________

Date of Birth ____________ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other ____________

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street ____________ City ____________ State ________ Zip ________

Phone: Home ____________ Work ____________ Mobile ____________

Employer *(if different from above)* ____________ **Occupation** ____________ **Phone** ____________

Address: Street ____________ City ____________ State ________ Zip ________

Dental Benefit Plan Information

Primary Dental Plan Name ____________ **Phone** ____________

Address: Street ____________ City ____________ State ________ Zip ________

Name of Insured ____________ **Date of Birth** ____________ **ID Number** ____________

Policy Number ____________ **Patient Relationship to Insured** ____________

Secondary Dental Plan Name ____________ **Phone** ____________

Address: Street ____________ City ____________ State ________ Zip ________

Name of Insured ____________ **Date of Birth** ____________ **ID Number** ____________

Policy Number ____________ **Patient Relationship to Insured** ____________

Medical Plan Information

Plan Name________________ **Phone** ________

Address: Street________ City________ State_____ Zip_____

Name of Insured________ **Date of Birth**________ **ID Number**________

Policy Number________ **Patient Relationship to Insured**________ **Deductible Amount**________

Whom may we thank for referring you?

☐ One of our valued patients *(name of patient)*________

☐ Advertisement________ ☐ Local Dental Society________

☐ Our Web site ☐ Other________

Please list other members of your immediate family who are patients in our practice

________ ________ ________ ________

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment - cash, check or credit card.
** Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 24-hour notice to reschedule an appointment. With less than 24-hour notice, a fee of $25.00 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.________(initial)

I have read the above and agree to the financial and scheduling terms.________(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One)________(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.________(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.________(initial)

Signature________________ Date________