# Medical Health History

**Patient Name** ____________________

Physician's Name ____________ Age ______ Date of Birth __________

Date of Last Physical ____________ Telephone # __________

Your estimate of overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

***Please check the box of any condition you have or may have had.***

## Allergies: ☐ None

☐Acetaminophen ☐Aspirin ☐Cephlasporins ☐Chlorhexidine (CHX) ☐Codeine
☐Erythromycin ☐Fluoride ☐Gluten ☐Ibuprofen ☐Latex/Rubber/Vinyl
☐Local Anesthetic ☐Metals: (Nickel, Gold, Silver ____________) ☐Nuts / Fruit ☐Penicillin
☐Sulfa ☐Tetracycline ☐Other ____________

## Health Issues:

☐Abnormal Bleeding/Hemophilia ☐Acid Reflux/GERD ☐AIDS/HIV ☐Anemia/Sickle Cell
☐Arthritis ☐Asthma ☐Autoimmune Disorder ☐Breathing/Sleep Problems ☐Cancer
☐Chemo/Radiation ☐Cold Sores/Fever Blisters ☐Diabetes A1C ______ ☐Dizziness/Fainting ☐Eating Disorder
☐Epilepsy/Seizures ☐Frequent Headaches ☐Glaucoma ☐High Cholesterol ☐Joint Replacement
☐Kidney Problems ☐Liver Problems/Hepatitis ☐Mental Disorder ☐Neurological Problems ☐Organ Transplant
☐Osteoporosis ☐Respiratory Disease (COPD) ☐Thyroid Problems ☐Tuberculosis ☐Ulcers

Explanation ____________________

☐Cardiovascular Disease ***(if checked, please specify)***

☐Angina ☐Arteriosclerosis ☐Artificial Heart Valve ☐Stroke ☐Congenital Heart Defect
☐Congestive Heart Failure ☐Coronary Heart Disease ☐Damaged Heart Valve ☐Heart Attack ☐Heart Murmur
☐High or Low Blood Pressure ☐Infective Endocarditis ☐Mitral Valve Replacement ☐Pacemaker ☐Rheumatic Fever
☐Other ____________

☐Recent Surgeries ____________

## Are You:

☐Presently being treated for any other illness ____________
☐Aware of a change in your health in the last 24 hours: *(i.e. fever, chills, new cough or diarrhea)* ____________
☐Taking medication for weight management ____________
☐Often exhausted or fatigued ____________
☐Taking / Taken Bisphosphonates ____________
☐Experiencing frequent headaches ____________
☐A smoker, previously smoked or use smokeless tobacco ______
☐Taking birth control pills ____________
☐Currently pregnant ____________
☐Nursing ____________
☐Diagnosed with a prostate disorder ____________

## Medications:

*List all medications, supplements and vitamins*

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please make us aware of changes to your health history.**

Patient Signature ____________________ Date ____________

Doctor Signature ____________________ Date ____________

# Dental History Form

**Patient Name** ____________________________________________

Referred by______________________________________________ Age ______________

Previous Dentist's name ________________________________________ How long?________

Date of most recent dental exam ____/____/____ I see my Dentist (circle): 3 m, 6 m, 12m, other, not routinely

**What is your immediate concern?** ____________________________________________

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| On a scale of 1-10 (10 greatest), how important is your dental health? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| On a scale of 1-10 (10 greatest), how would you rate your current dental health? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| On a scale of 1-10 (10 greatest, how fearful are you of dental treatment? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Personal History

| | Yes | No |
|---|---|---|
| 1. Have you had an unfavorable dental experience? | ☐ | ☐ |
| 2. Have you ever had complications from past dental treatment? | ☐ | ☐ |
| 3. Have you ever had trouble getting numb or had any reactions to local anesthesia? | ☐ | ☐ |
| 4. Do you have, or have you had any teeth removed or teeth that never developed? | ☐ | ☐ |
| 5. Did you ever have orthodontic treatment, braces, or your bite adjusted? | ☐ | ☐ |

## Gum/Bone History - Periodontal

| | Yes | No |
|---|---|---|
| 6. Do your gums bleed or do they hurt during brushing/flossing? | ☐ | ☐ |
| 7. Have you ever been told you have gum disease or are losing bone around your teeth? | ☐ | ☐ |
| 8. Have you ever noticed an unpleasant taste/smell in your mouth? | ☐ | ☐ |
| 9. Does anyone in your family have a history of periodontal/gum disease? | ☐ | ☐ |
| 10. Have you experienced gum recession (teeth look longer)? | ☐ | ☐ |
| 11. Have you ever had any teeth become loose on their own? | ☐ | ☐ |

## Tooth Structure History - Cavities

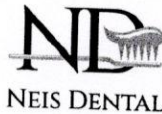
| | Yes | No |
|---|---|---|
| 12. Have you had any cavities within the past 3 years? | ☐ | ☐ |
| 13. Does the amount of your saliva in your mouth seem to little or do you have trouble eating/swallowing food? | ☐ | ☐ |
| 14. Do you feel or notice any holes on the tops of your teeth? | ☐ | ☐ |
| 15. Are your teeth sensitive to hot, cold, biting, sweets, etc or do you avoid brushing any area? | ☐ | ☐ |
| 16. Do you have grooves or notches on your teeth near the gum line? | ☐ | ☐ |
| 17. Have you ever broken, chipped, cracked any teeth or had a toothache? | ☐ | ☐ |
| 18. Do you get food caught between your teeth? | ☐ | ☐ |

## Occlusion History - Bite, Jaw & TMJ

| | Yes | No |
|---|---|---|
| 19. Do you have problems with your jaw joint? (pain, popping, cracking, locking, etc.) | ☐ | ☐ |
| 20. Do you avoid chewing gum, carrots, nuts, hard or chewy foods? | ☐ | ☐ |
| 21. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | ☐ | ☐ |
| 22. Are your teeth becoming more crooked, crowded, or overlapped? | ☐ | ☐ |
| 23. Are your teeth developing spaces or becoming loose? | ☐ | ☐ |
| 24. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? | ☐ | ☐ |
| 25. Do you clench your teeth during the day or night or wake with a headache? | ☐ | ☐ |
| 26. Do you wear, or have you ever worn, a bite appliance? | ☐ | ☐ |

## Cosmetic History - Smile

| | Yes | No |
|---|---|---|
| 27. Is there anything about your appearance of your teeth that you would like to change? | ☐ | ☐ |
| 28. Have you ever whitened/bleached your teeth? | ☐ | ☐ |
| 29. Have you felt uncomfortable or self-conscious about the appearance of your teeth? | ☐ | ☐ |
| 30. Have you been disappointed with the appearance of previous dental work? | ☐ | ☐ |




# Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. By making our policies clear we hope to avoid any problems or misunderstandings.

Please note 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, and Visa. Outside financing with Care Credit is available upon request and approval.

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

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 up to 35% of the unpaid balance.

Do You Have Insurance?
As a courtesy to you we will help you process all 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's 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 sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, and the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express, or Care Credit at the time we provide the service to you.

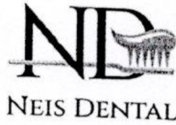
Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Any appointment for which a patient arrives more than 15 minutes late is subject to being rescheduled at the discretion of the provider. For any appointment where the patient does not show up and does not call to inform us that they will not be able to attend, will be subject to a $50 charge for each hour of time blocked for the appointment.

Consent:

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. I understand that responsibility payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Signature: ______________________________ Date: ____________________




# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If YES, please name the members allowed:

______________________________________________

______________________________________________

This consent was signed by: ______________________________ (PRINT NAME PLEASE)

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________