

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____

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)

- | | | |
|--------------------------------|--------------------------|-------------------------|
| Chest pain (angina) | Blood in stools | Frequent vomiting |
| Fainting spells | Diarrhea or constipation | Jaundice |
| Recent significant weight loss | Frequent urination | Dry mouth |
| Fever | Difficulty urinating | Excessive thirst |
| Night sweats | Ringing in ears | Difficulty swallowing |
| Persistent cough | Headaches | Swollen ankles |
| Coughing up blood | Dizziness | Joint pain or stiffness |
| Bleeding problems | Blurred vision | Shortness of breath |
| Blood in urine | Bruise easily | Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

- | | | |
|---------------------------------|---------------------------------|----------------------------|
| Heart disease | AIDS/HIV | Psychiatric care |
| Family history of heart disease | Surgeries | Osteoporosis |
| Heart attack | Hospitalization | Thyroid disease |
| Artificial joint | Diabetes | Asthma |
| Stomach problems or ulcers | Family history of diabetes | Hepatitis |
| Heart defects | Tumors or cancer | Sexual transmitted disease |
| Heart murmurs | Chemotherapy | Herpes |
| Rheumatic fever | Radiation | Canker or cold sores |
| Skin disease | Arthritis, rheumatism | Anemia |
| Hardening of arteries | Emphysema or other lung disease | Liver disease |
| High blood pressure | Kidney or bladder disease | Eye disease |
| Seizures | Stroke | Transplants |
| Cosmetic surgery | Eating disorders | Tuberculosis |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

- | | | |
|-------------------------------------------|--------------|--------------|
| Aspirin | Valium | Tetracycline |
| Darvon | Demerol | Vicodin |
| Codeine | Penicillin | Percodan |
| Local anesthetic (Novacaine or Xylocaine) | Latex | Food |
| Nitrous oxide | Erythromycin | Metal |
| Others: _____ | | |

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

- | | | |
|----------------------------|--------------------------|-------------|
| Recreational drugs | Tobacco in any form | Antibiotics |
| Over-the-counter medicines | Alcohol | Supplements |
| Weight loss medications | Bisphosphonate (Fosamax) | Aspirin |
| Please list: _____ | | |

VI. WOMEN ONLY

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

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please 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

Patient Name: _____ Date: _____
Last First MI

Male Female Social Security # _____ Drivers License # _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Email: _____

(Cellular) _____ Emergency Contact Person _____ Ph # _____

Address: _____
Street Apartment #

City State Zip Code

Employment Information

The following employment information is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Dental Insurance Information

Primary Insurance

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ Insured's Social Security # _____

Patient's relationship to insured: Self Spouse Child Other _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

ID# _____ Group # _____ Insurance Plan Phone # _____

Secondary Insurance

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ Insured's Social Security # _____

Patient's relationship to insured: Self Spouse Child Other _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

ID# _____ Group # _____ Insurance Plan Phone # _____

Consent for Services

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 1½% per month (18% 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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my 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: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____