HEALTH HISTORY

Please print and complete form, and bring to your first appointment. Thank you.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
3. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
If yes, explain _____		
4. (Women) Are you pregnant/trying to get pregnant? If so, give due date _____	☐	☐
Are you nursing?	☐	☐
5. Do you use tobacco in any form? If yes, how much _____	☐	☐

Do you have or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Sinus problems	☐	☐	Thyroid condition/goiter	☐	☐	Stent with releasing medication*	☐	☐
Stroke	☐	☐	Hypoglycemia	☐	☐	Arthritis/rheumatism	☐	☐
Headaches	☐	☐	Rheumatic fever	☐	☐	Artificial joints/limbs	☐	☐
Convulsions/epilepsy	☐	☐	Heart murmur	☐	☐	Osteoporosis	☐	☐
Numbness/tingling	☐	☐	Chest pain	☐	☐	Hepatitis A	☐	☐
Dizziness/fainting	☐	☐	Heart attack/trouble	☐	☐	Hepatitis B or C	☐	☐
Psychiatric treatment	☐	☐	High blood pressure	☐	☐	Radiation therapy	☐	☐
Emphysema	☐	☐	Mitral valve prolapse	☐	☐	Chemotherapy	☐	☐
Asthma/hay fever	☐	☐	Artificial heart valve*	☐	☐	Tumors or growths	☐	☐
Difficulty breathing while lying down	☐	☐	Pacemaker	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Heart surgery	☐	☐	HIV+	☐	☐
			Stent	☐	☐	AIDS	☐	☐

6. Are you **ALLERGIC** or have you ever experienced any reaction to the following?

Local anesthetics	☐	☐	Latex	☐	☐	Erythromycin	☐	☐
Penicillin	☐	☐	Aspirin	☐	☐	Other allergies _____		
Other antibiotics	☐	☐	Codeine	☐	☐			
Sulfa drugs	☐	☐						

7. Are you TAKING any of the following?

Antibiotics	☐	☐	Cortisone/steroids	☐	☐	Nitroglycerine	☐	☐
Sulfa drugs	☐	☐	Tranquilizers	☐	☐	Aspirin	☐	☐
Blood thinners (e.g., Plavix)	☐	☐	Insulin/other diabetes drugs	☐	☐	Osteoporosis drugs (e.g., Actonel,		
Blood pressure medication	☐	☐	Recreational drugs	☐	☐	Fosamax, Boniva, Reclast)	☐	☐
Thyroid medication	☐	☐	Digitalis/other heart medications	☐	☐	Other medication not listed here	☐	☐
Antihistamines/allergy drugs/cold remedies	☐	☐						

If yes to any of the above, list name of medication and dosage below:

1. _____
2. _____
3. _____
4. _____

8. Physician's Name _____ Phone _____
9. Have you ever had any serious trouble associated with previous dental treatment? _____
10. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
11. Date of last dental visit _____
12. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
    If so, when? _____
13. Do you wish to talk with the dentist privately about any problem or concern? _____

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I understand that the information I have given today is correct to the best of my knowledge. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status at the next appointment.

Signature of Patient (Parent or Guardian) _____ Date _____

Doctor's Signature _____ Date _____

CONFIDENTIAL

Patient Registration Information

Date _____

Name _____ Patient # _____
First Mi Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address _____ City _____ State/Prov. _____ Zip/P.C. _____

Birthdate _____ Home Phone _____ Work Phone _____

E-Mail _____ Cell Phone _____

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your or your parent/guardian's employer _____ Occupation _____

Business address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

If you are a student, name of school/college _____ City _____ State/ Prov. _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

City _____ State/ Prov. _____ Zip/ P.C. _____ SS #/SIN _____

Driver's license # _____ Birthdate _____ Financial institution _____

E-Mail _____ Cell Phone _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____

Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Please Continue... ☞

Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____

Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actucl bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____ _____

Signature of patient or parent/guardian if minor — Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

_____ Cash

_____ Personal Check

_____ Credit Card _____Visa _____MasterCard

Card # _____ Expiration Date _____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.