PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joints
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Family History Of Periodontal Diseas
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV / AIDS
☐ ☐	Have You Ever Taken Bisphosphona

Y N	Conditions
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Murmur
☐ ☐	Heart Surgery
☐ ☐	Hepatitis
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Osteoporosis
☐ ☐	Pace Maker / Defibrilator
☐ ☐	Pneumocystitis
☐ ☐	Premedication For Dental Appt
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems
☐ ☐	Stroke
☐ ☐	Sulfa Allergy

Y N	Conditions
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice
☐ ☐	

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

I consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

HIPPA CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature:_____Date:_____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient_____

FINANCIAL POLICY

We will work hard to help you comfortably afford the care you need and desire. We offer the following payment options so you may have the opportunity to decide which best suits your needs:

Insurance:
Our office will work with you to help you get the maximum insurance benefit available. Most dental insurance plans do not cover 100% of your treatment cost. You will be required to pay your deductible & co-payment on the day services are rendered. We will estimate your coverage based on the most up to date information available. These are only estimates and **ARE NOT** a guarantee of payment. Your insurance policy is a legal contract between you & your insurance carrier. Our office is not & cannot be a part of that legal contract. If after 60 days, the insurance carrier has not paid the claim, you will be responsible for the total balance. Fees incurred with any collection procedures will be added to your balance.

Payment Options:

1. **Cash, check, or credit card**. We accept VISA, MasterCard, Discover, American Express. Returned checks will be assessed the current NSF fee.
2. **Outside Financing**. Care Credit is available for extensive treatment. Plans with 12, 18 & 24 months interest free are available. Subject to credit approval.

Down Payment for Future Treatment: Any extensive/lengthly appointments will require payment at the time they are scheduled. We will notify if this is necessary. If you do not keep that scheduled appointment, or cancel with less than a 48 hour notice, your deposit will be forfeited.

APPOINTMENT POLICY

When an appointment is made that time is reserved exclusively for you. We strongly encourage you to keep your scheduled appointment. If you must change your appointment, we require **at least 48 hours notice.** Any schedule changes **must be done directly with a staff member during business hours** and not left on the answering machine. We do our best to stay on time, and we request that you be on time also. Any patient who is more than 20 minutes late *may* be reappointed at the discretion of the doctor.
Please be aware that if you need to reschedule any future appointments and fail to give at least 24 hour notice, you will be charged a minimum of $50.00 and up to 20% of the total appointment fee.

We welcome you to our practice and look forward to helping you get the healthy, beautiful smile you have always wanted. If there is anything we can do to make your visits here more relaxing, please don't hesitate to ask one of our staff members.

I have read and understood all of the above information. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

_____ _____

(patient or guardian signature) **(date)**