



HEALTH HISTORY: For your safety please answer all questions carefully and honestly

Patient Name: _____ Phone: (____) _____ Dentist Name: _____ Phone: (____) _____
 Height: _____ Weight: _____ Are you in good health? YES NO Are you under the care of a physician? YES NO Date of last visit:
 _____ Have there been any changes in your general health in the past year? YES NO If so, for what are you being treated?
 _____ Have you ever been hospitalized? YES NO List previous surgeries/dates:

HAVE YOU EVER HAD:

- | | Y | N |
|------------------------------------------|--------------------------|--------------------------|
| 1. Rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Damaged heart valves/mitral prolapse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Chest pain, angina? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Heart attack(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Irregular heart beat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Cardiac pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Heart surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Low blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have anorexia or bulimia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Kidney trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you on dialysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Hepatitis or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. A tumor or growth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Radiation treatment/chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Thyroid trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Hay fever/sinus problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Other medical concerns? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain: _____

DO YOU CURRENTLY HAVE:

- | | Y | N |
|-------------------------------------------|--------------------------|--------------------------|
| 1. Removable dental appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Bleeding tendency (abnormal bleeding)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Emphysema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Any other lung trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. AIDS or HIV infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Sexually transmitted diseases? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Convulsions, epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Mental health problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Habit-forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Stomach ulcers? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Infectious mononucleosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Contagious diseases? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain: _____

MEDICATIONS:

What kinds are you taking/what for?

1. Anticoagulants? _____
2. Other? _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES:

- Have you ever had a reaction to:**
- | | Y | N |
|--------------------------------------|--------------------------|--------------------------|
| 1. Local Anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Penicillin? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Other antibiotics? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other medication allergies: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Egg allergy? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Soy allergy? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Latex allergy? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN:

- | | Y | N |
|-----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Could you be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Estimated delivery date? _____ | | |
| 3. Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been treated for osteoporosis? If so, list medications (Boniva, Actonel, Fosamax): _____ | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN NOTE: Antibiotics (such as erythromycin, etc.) and some pain medications may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Notice of Privacy Practices Acknowledgment

I have read and agree: _____
 I have read and do not agree: _____
 Date: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/parent: _____ Date: _____

THE FACTS ABOUT INSURANCE

Please understand we are desirous to extend care to you and to work with you and any insurance coverage you may have.

1. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
2. It is imperative that we have an x-ray on file for our medical malpractice insurance and for your insurance coverage. If outside x-rays are brought to our office, there will be a duplication fee charge.
3. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.
4. For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefits, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of surgery the ESTIMATED uncovered portion of the total fee.
5. If you desire to know exactly what your insurance coverage will be, prior to surgery, then we can pre-determine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.
6. A finance charge of 1.5% per month will be added to your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.
7. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurance purposes.

Thank you for your understanding in this matter. Signature: _____ Date: _____