

HEALTH HISTORY

Please answer all of the questions accurately. The success of your dental treatment depends on this strictly confidential information.

Medical History

Circle One

- Do you consider yourself to be in good health? Yes No
- Have you been examined by your physician within the last year? Yes No
- Are you being treated for any condition by a physician now? For what? _____ Yes No
- Are you taking any medications presently? If so, please list including non-prescription. _____ Yes No
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- Do you use any tobacco products? cigarettes, cigars, pipe, smokeless _____ Yes No
- Have you ever had any complications following dental treatment? Yes No
- If yes, please explain: _____
- Do you take aspirin on a daily basis? If so, how much? _____ Yes No
- Are you allergic to any medications? (circle) Penicillin, Aspirin, Codeine, Iodine, Sulfa _____ Yes No
- Do you have any health problems that need further clarification? Yes No
- If yes, please explain: _____

Have you ever had or been treated for any of the following? Please check or circle those that apply:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux, Bulemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Rheumatism (arthritic) |
| <input type="checkbox"/> AIDS,ARC,HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure ___/___ | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergies-pollen,etc | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Immune system | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Allergies-latex,nickel | <input type="checkbox"/> Emphysema,Bronchitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy,Seizures | <input type="checkbox"/> Liver Disease, Jaundice | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Minocycline antibiotics | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fever Blisters,Herpes I/II | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma, Eye Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Female:currently Pregnant
due date: _____ |
| <input type="checkbox"/> Blood Disease,Hemophilia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Female:currently Nursing |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack,Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Cancer,Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |

Name of Physician: _____ Phone: _____

Dental History

Have you experienced any of the following habits, symptoms or treatment? Please check those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain/swelling with the teeth | <input type="checkbox"/> Periodontal (gum) treatments | <input type="checkbox"/> Grind or clinch your teeth |
| <input type="checkbox"/> Teeth sensitive to hot/cold/sweets | <input type="checkbox"/> Gums that bleed or feel tender | <input type="checkbox"/> Jaws click or pop when you chew |
| <input type="checkbox"/> Teeth sensitive to biting pressure | <input type="checkbox"/> Bad odors or tastes in your mouth | <input type="checkbox"/> Crowded teeth |
| <input type="checkbox"/> Apprehensive about dental treatment | <input type="checkbox"/> Child:thumb sucking | <input type="checkbox"/> Orthodontic treatment (braces) |

Date of Last Dental Visit: _____ Reason for this visit: _____

Consent for Services

All of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist at the next appointment. As a condition of your treatment by this office, financial arrangements must be made in advance. 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 have been made aware of this office's HIPAA Notice of Privacy Practices which is displayed at the receptionist's desk. 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 agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: (circle) Parent or Guardian