HEALTH HISTORY

So that we may provide you with the best possible care, please complete and sign both sides of this form. All information is completely confidential.

PATIENT NAME_____

Name of Person or Office referring you to our practice:_____

1. Have you been under the care of a medical doctor or hospitalized during the past 2 years? ..... Yes / No

   If yes, for what? _____

Physician's Name_____ Phone _____
Address _____City/State/Zip_____

2. Have you taken any medication or drugs during the past 2 years? ..... Yes/ No
3. Please list the medications you take now and the dosage, including regular doses of aspirin:

   _____

4. Have you ever taken or are you taking prescription medication(s) for Osteoporosis? ..... Yes / No
5. Have you ever been asked to Pre-medicate with antibiotics prior to dental treatment? ..... Yes / No

   If yes, for what? _____

6. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ..... Yes / No

   If yes, please list medication and your reaction _____

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item:

Heart Condition…….	Yes	No	Ulcers……...	Yes	No	Hepatitis A B C (circle)…	Yes	No
Chest Pain…….	Yes	No	Diabetes……..	Yes	No	Venereal Disease……...	Yes	No
Congenital Heart Disease…..	Yes	No	Thyroid Disease…….	Yes	No	H.I.V. Positive/AIDS……..	Yes	No
Heart Murmur……..	Yes	No	Glaucoma……	Yes	No	Neurological Disorders……..	Yes	No
High Blood Pressure……	Yes	No	Contact Lenses……	Yes	No	Blood Transfusion……..	Yes	No
Mitral Valve Prolapse……	Yes	No	Emphysema……..	Yes	No	Hemophilia……	Yes	No
Artificial Heart Valve…….	Yes	No	Chronic Cough……..	Yes	No	Sickle Cell Disease…….	Yes	No
Heart Pacemaker…….	Yes	No	Tuberculosis……..	Yes	No	Bruise Easily……	Yes	No
Rheumatic Fever……..	Yes	No	Asthma……	Yes	No	Liver Disease……..	Yes	No
Arthritis/Rheumatism……	Yes	No	Hay Fever……	Yes	No	Yellow Jaundice……..	Yes	No
Cortisone Medicine……...	Yes	No	Latex Sensitivity…….	Yes	No	Epilepsy or Seizures……..	Yes	No
Swollen Ankles……..	Yes	No	Allergies or Hives……..	Yes	No	Fainting or Dizzy Spells……..	Yes	No
Stroke……..	Yes	No	Sinus Trouble……	Yes	No	Psychiatric/Psychological Care.	Yes	No
Diet (special/restricted)……	Yes	No	Radiation Therapy…….	Yes	No	Nervous/Anxious…….	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	Chemotherapy……	Yes	No	Smoke or chew tobacco…….	Yes	No

8. Do you have or have you had any disease, condition or problem not listed?..... Yes / No

   If yes, please list: _____

9. **Women Only:** Are you: **Pregnant?** Yes, ____ Months / No **Nursing?** Yes / No **Taking birth control pills**? Yes / No
10. Is there anything about having dental treatment that you would like us to know? …….. Yes / No

    If yes, please describe?_____

History Review

Dentist Signature:_____ Date_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature_____Date _____

(Please complete other side)

PATIENT REGISTRATION

1 PATIENT INFORMATION

LAST NAME FIRST M.I.

PREFERS TO BE CALLED

ADDRESS

CITY STATE ZIP

HOME PHONE WORK PHONE

CELL PHONE

BIRTHDATE MALE/FEMALE MARITAL STATUS:

SOCIAL SECURITY NUMBER

OCCUPATION EMPLOYERS NAME

ADDRESS

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH RELATIONSHIP

INSURED'S ID NUMBER

INSURED'S SOCIAL SECURITY NUMBER

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH RELATIONSHIP

INSURED'S ID NUMBER

INSURED'S SOCIAL SECURITY NUMBER

3 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT SOCIAL SECURITY NUMBER

ADDRESS

CITY STATE ZIP

PHONE NUMBER

IS ANY OTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?

NAME RELATIONSHIP

YOUR SPOUSE

NAME

OCCUPATION EMPLOYERS NAME

ADDRESS CITY

PHONE NO FAX NO

4 EMERGENCY CONTACT

EMERGENCY CONTACT

PHONE NUMBER

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY STATE ZIP

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 patient's 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 18% APR 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 6 months from the date of the patient's first examination with this office. A processing fee may apply in conjunction with collection recourse. A set-up fee will be assessed all short notice/failed appointments (within 24 hrs).

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the responsible value of said services to said Doctor, or his assignee, at the time said services are rendered or by due date of billing if credit shall be extended with financial arrangements agreed upon. 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 and agree to their content.

_____ Date: _____

Signature of Patient, Parent or Guardian

_____ Date: _____

Signature of Payment/Responsible Party or Guarantor