HEALTH HISTORY

A COMPLETE AND ACCURATE HEALTH HISTORY IS ESSENTIAL FOR PROPER DENTAL CARE

Your cooperation in accurately completing this confidential questionnaire is appreciated.

Please print your Name: _____

Who is your personal Physician: _____ **Doctor's Office/Location** _____

Date of last complete physical exam: _____ **Doctor's Phone Number** _____

MEDICAL HISTORY *(Place an X under "Yes" or "No")*

	YES	NO
Are you currently under medical treatment?	_____	_____
Are you taking any medicines?	_____	_____

List your medications _____

I have or had:	YES	NO
Prosthetic Heart Valves	_____	_____
Infectious Endocarditis	_____	_____
Congenital Heart Disease	_____	_____
Cardiac Transplant	_____	_____
Heart Attack or Angina	_____	_____
Heart Disease or Surgery	_____	_____
Low Blood Pressure	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Asthma/Breathing problems	_____	_____
Hepatitis (A, B, C, …)	_____	_____
AIDS or HIV infection	_____	_____
Tuberculosis	_____	_____
Bleeding Problems	_____	_____
Artificial Joints (knee, hip..)	_____	_____
Metal Pins, Plates or Screws	_____	_____
Cancer- please explain	_____	_____

Other – please explain _____

_____

Are you allergic to:	YES	NO
Penicillin	_____	_____
Other Antibiotics	_____	_____
Latex	_____	_____
Local Anesthetic/Novocaine	_____	_____
Codeine	_____	_____
Other	_____	_____

Women, please answer the following:

Are you Pregnant?	_____	_____
Are you Breastfeeding	_____	_____
Do you take Birth Control?	_____	_____
Do you take Estrogen?	_____	_____

_____ _____

SIGNATURE **DATE**

This information will enable us to complete our records. Please complete all sections on both sides as completely as possible and sign the health history on the other side of this sheet.

Patient's Name:_____
FIRST MIDDLE LAST

Home Address:_____
STREET TOWN ZIP

Patient's Home#:_____ Patient's Work#:_____

Patient's Cell#:_____ Spouse's Work#:_____

Date of Birth:_____ Patient's E-mail Address:_____

Whom may we thank for referring you to our office?_____

_____

OUR OFFICE POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Policy, which we require you read and sign prior to any treatment. All patients must complete our Medical History before seeing the doctor. Please let us know if you have any questions or concerns.

Regarding Insurance

We may accept assignment of insurance benefits. However, your portion of the bill is to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services.

Patients Without Insurance

Full Payment is due at time of service. We accept cash, checks, or VISA/MASTERCARD/AMERICAN EXPRESS.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, American Express, or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of 1.5% as provided by state law.

Family Members

Sometimes it is necessary to discuss treatment with a spouse or schedule an appointment for an adult child. We may discuss treatment, payment, and other healthcare information with family members.

I have read the Office Policy. I understand and agree to this Office Policy:

_____ _____
SIGNATURE DATE

FOR INSURANCE PURPOSES

1) Do you have dental insurance? **YES** **NO**

2) Name of the Insurance Company_____

3) Group Number _____

4) Insured's Name and Date of Birth _____

5) Insurance I.D./Soc.Sec.#_____