Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics _____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals _____ ☐ ☐ ☐
Latex (rubber) _____ ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals _____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date: _____
Hemophilia ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐
Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
If yes, specify: _____
Sleep disorder ☐ ☐ ☐
Do you snore? ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Specify: _____
Recurrent Infections ☐ ☐ ☐
Type of infection: _____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands in neck ☐ ☐ ☐
Severe headaches/ migraines ☐ ☐ ☐
Severe or rapid weight loss ☐ ☐ ☐
Sexually transmitted disease ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services Payment

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not included in your contract. 2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover. 3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.

We must emphasize that as health care providers, **our relationship is with you**, not your insurance company. While filing your insurance claims for our patients is a courtesy that was extended, **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.** We do realize that there are times that a temporary financial problem may affect your payment of your account. In that case, PLEASE, contact our financial advisor for assistance so that we may be able to set up payment options for you. If you have any questions, feel free to ask us. We will be glad to help.

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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

FINANCIAL POLICY

Thank you for choosing **Old Canton Dental Care** as your dental care provider. We are committed to your treatment being successful. The following is a statement of our **Financial Policy,** which we require that you read and sign prior to any treatment. Please understand this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. This also allows us to concentrate on what we do best…taking care of you.

Full payment is due at the time of service.

We accept cash, checks, and all major credit cards.

Interest free financing is available with credit approval for treatment through a couple of financial service companies. Please inquire at the front desk for more information.

INSURANCE:

We may accept assignment of insurance benefits; however, we do require deductibles and co-payments to be paid at the time of service. The balance is your responsibility until paid in full. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. We must have **complete** and up- to-date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days, the balance will be billed to you.

Initial _____

BILLING CHARGES:

A billing charge will be applied to any account which has a balance 45 days past due. This monthly fee will equal 18% APR or a minimum of $5.00. Initial _____

COLLECTION FEES:

Accounts that remain unpaid after 45 days may be turned over to our internal collection department. These collection efforts will incur collection fees internally that may total up to 50% of the account balance. When an account becomes 90 days past due, collection action may be taken outside of **Old Canton Dental Care**. In this event, you will be responsible for all collection and legal fees. Initial_____

MISSED APPOINTMENTS:

Unless cancelled at least **48 hours** in advance, there will be a $50.00 charge for broken appointments. Please help us to serve you and other patients more efficiently by keeping scheduled appointments.

Initial_____

RETURNED CHECKS:

If a check is returned unpaid, there will be a $35.00 charge and checks will no longer be accepted.

Initial_____

I, the undersigned, *assume financial responsibility* as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this Financial Policy.

X _____ Signature of Responsible Party

X _____Date

X_____ Print Name

Appointment Notification Preference

How would you prefer OCDC notify you of your future appointments?

Email_____ Text_____ Both_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this form

I, _____, have read a copy of Old Canton Dental Care's Notice of Privacy Policies.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could not be obtained because:

____Individual refused to sign

____Communication barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please specify)