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 _____ ☐ ☐ ☐

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 ☐ ☐ ☐

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:

Financial Policy

Patient Name: _____

We believe our patients deserve the best possible dental care we can provide. In an effort to maintain this high quality of care, it is vital that you read and understand the following regarding your financial obligation and insurance.

Please Read and Initial Each Paragraph:

Financial Obligation

_____ Payment for professional services is due at the time dental treatment is provided. You, the patient, are ultimately responsible for the total cost of your dental treatment.

Patients with Dental Insurance

_____ We file dental insurance claims ONLY AS A COURTESY to our patients. We are not responsible for what benefits your insurance company pays on a claim. We only assist you in ESTIMATING your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We assume no responsibility for any errors in filing your claim or for the accuracy of the estimate provided by our office.

_____ It is your responsibility to know whether or not you have exceeded your allowable limits, both in regards to benefit maximums and frequency limitations. Furthermore, if your insurance company chooses to pay benefits based on an alternative, lower-cost procedure than was actually performed, you will be billed for the difference.

_____ If we have received all of your insurance information 24 hours prior to your appointment, we will be happy to file your claim as a courtesy to you. If we have ***NOT***, however, you will be expected to pay for all services at the time of the appointment. We will then provide you with a claim form so that you can submit to your insurance company for direct reimbursement.

_____ We make no claim as to whether our office is in network with your insurance company. It is the patient's responsibility to verify in-network participation and coverage.

_____ If your insurance company has not paid your claim in 30 days, or fails to pay for any services rendered, our office will bill you for the balance, and it will be your responsibility to deal directly with your insurance company for reimbursement. If your balance is not paid within a total of 60 days, a finance charge of 1.5% will be added to your account each month until the balance is fully paid. If your insurance company subsequently reimburses our office for payment you have already made to our office, we will send you a refund or establish an account credit.

Cancellation Notice

_____ Since we have reserved a specified time for your appointment, other patients were denied that day and time. We therefore require a 48-Hour advance notice for ALL cancellation or rescheduling of appointments. If you cancel or reschedule your appointment with less than a 48-hour notice, or no show, you will be charged a $75 cancellation fee.

I have read, understood and agree in full to the above policies.

_____ _____

(Signature) (Date)

INSURANCE FACTS

Fact 1 - NO INSURANCE PAYS 100% OF ALL PROCEDURES
Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE
You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Fact 3 - DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED
When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), on average $50, is subtracted, leaving $100.00. The plan then pays 80% for this particular procedure. The insurance company will then pay 80% of $100.00, or $80.00. Out of a $150.00 fee they will pay an estimated $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

Office Policy
Concerning Dental Insurance Benefits

We believe our patients deserve the best possible dental care we can provide. In an effort to maintain this high quality of care, we would like to share this information with you regarding your dental insurance.

Your dental insurance is a tremendous benefit that your employer provides for you. Many times, understanding your benefits is confusing at best! We will do our best to assist you in this manner, but please keep in mind we are a third party; we have limited access to information regarding your dental benefits. **It is impossible for us to guarantee any payment from your insurance company.** Many plans have specific restrictions that you, the patient need to be aware of and you should consult your dental insurance handbook for details.

Regardless of what we calculate as your dental plan benefit in dollars, **we must stress the fact that you, the patient are responsible for the TOTAL cost of your dental treatment.** We are happy to extend to you the courtesy of filing your insurance claim to your primary insurance company for direct reimbursement. We do sometimes at our discretion resubmit claims in order to dispute an insurance decision; however, we cannot guarantee payment. Every dental claim will be submitted with the necessary x-rays and narrative.

Please keep in mind that your insurance company will never guarantee your benefits or tell us exactly what they will pay directly to us. This is why we can only estimate your portion.

We ask that you pay your estimated portion and deductibles at the time of service. If your insurance company has not paid your claim in 60 days, the balance will be billed to you and we ask that you deal directly with your insurance company for reimbursement.

Thank you for your understanding and cooperation.

Date: _____

Patient Name: _____

Signature: _____