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 Bus 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: Wight: 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 questions)	**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**		**YES**	**NO**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold. hat. sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you had any problems associated with previous dental treatment	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐	Date of your last dental exam:	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐	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**		**YES**	**NO**	**DK**
Are you now under the care of 3 physician?	☐	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )				If yes, what was the illness or problem?			
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
Are you in good health?	☐	☐	☐	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			
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:							

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?	☐	☐	☐
Join! Replacement. Have you had an orthopedic tote! 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*, Reciast. Prolia) for osteoporosis or Paget's disease, multipia mayeloma or metastatic cancer?	☐	☐	☐
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 in 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		YES	NO	DK
Local anesthetics _____	☐	☐	☐	Metals _____	☐	☐	☐
Aspirin _____	☐	☐	☐	Latex (rubber) _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐	Iodine _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐	Hay fever/seasonal _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐	Animals _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐	Food _____	☐	☐	☐
				Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or had 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.			
Cardiovascular disease	☐	☐	☐
Agnia	☐	☐	☐
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/Chernotherapy/ 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 lo 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 and all relevant patient health issue prior to treatment.
I certify that I have real and understand the above that information given on his form is accurate. I understand the importance of a truthful health history and that my dentist 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:

Comments: FOR COMPLETION BY DENTIST

_____

_____

_____

Advanced Dental Wellness Center

HIPAA COMPLIANCE: Patient Consent to Receive and Provide Mail, Telephone Messages, Billing and Dental Information

Patient's Name: (Please Print) _____
Last Name First Name Middle

1. Do we have permission to send recall/treatment appointment reminders to your home?
   Yes ___ No ___
2. Do we have your permission to leave the following information on your home answering machine or voicemail?
   - Appointment Information Yes ___ No ___
   - Billing Information Yes ___ No ___
   - Dental/ Medical Information Yes ___ No ___
3. Do we have your permission to leave the following information on your work answering machine or voicemail?
   - Appointment Information Yes ___ No ___
   - Billing Information Yes ___ No ___
   - Dental/ Medical Information Yes ___ No ___
4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?
   - Appointment Information Yes ___ No ___
   - Billing Information Yes ___ No ___
   - Dental/ Medical Information Yes ___ No ___
   - Advertisement and promotions related to dental services Yes ___ No ___
   - Recognizing special occasions like birthdays and "Thank-You" Yes ___ No ___
5. Do we have permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?
   - Appointment Information Yes ___ No ___
   - Billing Information Yes ___ No ___
   - Dental/ Medical Information Yes ___ No ___
   - Advertisement and promotions related to dental services Yes ___ No ___
   - Recognizing special occasions like birthdays and "Thank-You" Yes ___ No ___
6. I herby give permission to share any information concerning me with the person (s) named below: Name (s) _____ Relationship_____ Phone number_____
7. Relation to Patient: Self____Spouse____Parent____Child___Legal Guardian___Other_____

At any time if your home address, email or phone number changes please let us know so we can keep you updated on all current dental services and specials. At any time if you would like to stop receiving these messages kindly request to update a new form so we can respect your wishes. Thank you, we appreciate you and respect your privacy.

Print Name:_____ Signed: _____Date: _____ Witness: _____

Acknowledgment of Receipt of Notice of Privacy Practice &
Consent and Release Form

It is important that you are informed about your dental and overall health condition and proposed treatment including potential benefits and risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent to the treatment program.

I agree to indemnify, hold harmless, and release from any and all liability the service provider as well as any officers, directors, assigns, insurers, affiliates or employees of the provider for any condition, result, or negligence known or unknown that may arise because of any treatment that I receive. Initials:_____

I consent to this procedure today and for all subsequent treatments.
Patient Signature: _____Date: _____

I, (Initials) _____have received a copy of this office's Notice of Privacy Practices and certify that I have read, and that I had enough opportunity for discussion and to ask questions.
Patient Signature: _____ Date: _____

The **referral** of your friends and family is **the greatest compliment** you can give us.
Thank you for your trust.

REFER A FRIEND – You BOTH will receive a $25.00 credit to use towards dental treatment. Valid for new customers only.

How did you learn about, or who referred you to, our dental office?

- Yellow Pages _____
- Insurance Plan _____
- Newspaper _____
- Website _____
- Your employer _____
- Direct Mail Postcard ____
- Other _____
- Name a person / medical office who referred you _____

Thank you for being a loyal patient here at Advanced Dental Wellness Center.
We appreciate you and your time spent here today.

Please let us know how we can make your visit with us a great one. As a courtesy to you we offer complementary:

Tea
Coffee
Water
Blanket & Pillow

TERMS AND CONDITIONS OF SERVICE

Medical Information: The undersigned hereby certifies that all information provided to *Advanced Dental Wellness Center* is true, correct and complete and agrees to promptly inform *Advanced Dental Wellness Center* of any changes in any information (including regarding and Department). *Advanced Dental Wellness Center* is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Department to obtain payment for services, determine insurance benefits, or otherwise as required by law. *Advanced Dental Wellness Center*, is authorized to contact the undersigned at any telephone number, email, text message concerning promotion, new technology, innovation, advertisement or other provided above (unless otherwise revoked in writing) to discuss this form and any billing, or other matter related to any treatment (including for any Department or Services provided at Advanced Dental Wellness Center. Patient/Guardian Initials:_____

Treatment Information Consent: The undersigned authorizes *Advance Dental Wellness Center* and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by *Advanced Dental Wellness Center* or any dentist or any other person employed or contracted by *Advanced Dental Wellness Center* up regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for or provide at least 48 hours advance notice of cancelation of, any appointment for any reason will result in a broken appointment fee. *Advanced Dental Wellness* does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist dentist's supervision) and agrees to hold harmless *Advanced Dental Wellness Center*. Fees in treatment plans for noninsurance/discount plan patients are only valid for 30 days; all non-insurance, insurance and discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors. Patient/Guardian Initials:_____

Financial Responsibility: Insurance: THE UNSERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF *Advanced Dental Wellness Center.* WHETHER OR NOT COVERED BY INSURANCE, THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTABLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT TIME SERVICES ARE PERFORMED. For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. *Advanced Dental Wellness Center* submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not a guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 'PA% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balance are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by *Advanced Dental Wellness Center* relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether suit is filed. *Advanced Dental Wellness Center* reserves the right to terminate or deny any treatment if the patient's account is delinquent. Patient/Guardian Initials:_____

Assignment of Benefits: Authorization and Release: The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to *Advance Dental Wellness Center* all insurance benefits covering the undersigned or any Department for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; *Advanced Dental Wellness Center* is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to *Advance Dental Wellness Center.* Patient/Guardian Initials:_____

Notice of Privacy Practices. The undersigned has reviewed a copy of Advanced Dental Wellness Center Notice of Privacy effective April 14, 2003, as amended. I have read the above terms and conditions of service by Advance Dental Wellness Center and understand and accept such terms:

Signature of Patient:_____ Date:_____ Signature of Witness:_____ Date:_____