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	☐	☐	☐

	Yes	No	DK
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*
( )

	Yes	No	DK
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:

Deefield Family Dentistry
Tracey Pike, DMD
Patient Registration Form

Patient Name: _____
Preferred Name:_____ Birth Date:_____
SS#:_____Drivers Lic #:_____ Marital Status: S__M__D__W__
Home Address:_____
City:_____ State:_____ Zip:_____
Home #:_____ Cell #:_____
Employer Name and Address_____
Occupation:_____ Work #:_____
E-mail Address:_____
Would You Like to Receive Dental Reminders Via Text/E-mail? Y_____ N_____
Referred By_____

Person Responsible for Account (If Other than Patient):_____
Relationship:_____ SS#:_____ Birth Date:_____
Home Address (If Different):_____
Employer Name and Address:_____
Occupation:_____ Work #:_____

Emergency Contact Information (relative not living with you)

Name:_____
Address:_____
City:_____ State:____ Zip:_____ Phone #:_____

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Insured's Name:_____	Insured's Name:_____
Insured's DOB:_____	Insured's DOB:_____
Insured's Employer:_____	Insured's Employer:_____
Insured's Company:_____	Insured's Company:_____
Group #:_____	Group #:_____
Ins. Company Phone #:_____	Ins. Company Phone #:_____

Name on Credit Card:_____
Credit Card #:_____ Authorization Code:_____
Expiration Date:_____ Credit Type (MC/Visa/Discover/Amex):_____
To be used for Services not covered by Insurance

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE & CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

I may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

_____ _____
Printed Name Signature

Dependents:
_____

How would you like to be addressed when summoned from the reception area:
{ } First name only { } Proper sir name { } Other:_____

Please list any other parties who can have access to your health information:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorized Deerfield Family Dentistry to confirm my appointments, treatment and billing information via:
{ } cell phone { } text message { } home phone
{ } work phone confirmation { } email confirmation { } any of the above

I authorize information about my health be conveyed via:
{ } cell phone { } text message { } home phone
{ } work phone confirmation { } email confirmation { } any of the above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote you improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule provide you this information with your knowledge and consent.

Office use only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
{ } Emergency treatment { } I could not communicate with the patient

{ } The patient was unable to sign because:_____

{ } Other:_____

DEERFIELD FAMILY DENTISTRY PLLC

Deerfield Family Dentistry

Financial Policy

Thank you for choosing our office as your dental health care provider. Our office provides quality, comprehensive dentistry to our patients. In return, our patients are responsible to us for their financial obligation. Insurance benefits are a terrific aid in helping to fulfill those obligations. We are a Delta Premier Provider. Our office will assist you at no charge in securing the maximum insurance benefits you are entitled to. **IT IS NOT OUR RESPONSIBILITY NOR OUR INTENT TO ACT AS MEDIATOR BETWEEN YOU AND YOUR INSURANCE COMPANY.** Your insurance policy is a contract between you, your employer, and your insurance company. **IT IS YOUR RESPONSIBILITY TO MONITOR YOUR REMAINING BENEFITS AVAILABLE** so as to not unexpectedly run over the maximum.

We ask that you pay your portion on the day of services. We accept cash, checks, MasterCard, Visa, American Express, and Discover cards. There is a fee of $25 for any returned checks. **WE DO NOT ACCEPT MONTLY PAYMENT PLANS.** Most insurance companies will reimburse patients within two weeks. If your insurance carrier has not paid their portion within 60 days of the date of service, that balance now becomes your responsibility also.

Any balance unpaid after 30 days is subject to an interest rate of 10%. Be aware that your failure to keep your account current may result in Deerfield Family Dentistry being unable to provide additional dental services except for dental emergencies. In case of default on payment of this account, you will be charged the collections costs and reasonable fees incurred in attempting to collect on this amount or any future outstanding account.

Due to staffing requirements, for your visit there will be a charge of $75.00 for any missed appointments. If unable to keep an appointment, 72 hours notice is required to avoid this fee.

We offer 5% senior citizen discount to our patients 65 years young.

We offer discounts for payments made before your scheduled appointment.

We also offer Care Credit, which is an extended financing solution to include up to 12 months of interest free loans.

By signing, you are also authorizing release of any medical or other information necessary to process a claim. You are also authorizing payment of benefits for services rendered to either Dr. Pike or the subscriber according to the policy of her practice.

The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependents is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance. I hereby authorize this office to obtain a credit report from a credit reporting agency for the purpose of considering payment options.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient/Guardian Signature _____ Date _____

I have been offered copies of Dr. Pike's "Notice of Privacy Practices" and the Dental Restorative Materials Fact Sheet and have been given the opportunity to ask any questions that I may have regarding these "Notices".

Patient/Guardian Signature _____ Date _____

*some restrictions may apply