

Health History Form



American Dental Association
www.ada.org

E-mail:

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:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
Last	First	Middle	()		()	
Address:			City:		State:	
Mailing address					Zip:	
Occupation:			Height:	Weight:	Date of birth:	Sex: M F
SS# or Patient ID:		Emergency Contact:		Relationship:	Home Phone:	Cell Phone:
					()	()
				<i>Include area codes</i>		
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 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		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, hot, sweets or pressure?	☐ ☐ ☐	Do you have any clicking, popping or discomfort in the jaw?	☐ ☐ ☐
Does food or floss catch between your teeth?	☐ ☐ ☐	Do you brux or grind your teeth?	☐ ☐ ☐
Is your mouth dry?.....	☐ ☐ ☐	Do you have sores or ulcers in your mouth?	☐ ☐ ☐
Have you had any periodontal (gum) treatments?	☐ ☐ ☐	Do you wear dentures or partials?	☐ ☐ ☐
Have you ever had orthodontic (braces) treatment?	☐ ☐ ☐	Do you participate in active recreational activities?.....	☐ ☐ ☐
Have you had any problems associated with previous dental treatment?.....	☐ ☐ ☐	Have you ever had a serious injury to your head or mouth?.....	☐ ☐ ☐
Is your home water supply fluoridated?	☐ ☐ ☐	Date of your last dental exam:	
Do you drink bottled or filtered water?	☐ ☐ ☐	What was done at that time?	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		Date of last dental x-rays:	
Are you currently experiencing dental pain or discomfort?	☐ ☐ ☐		
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 a physician?	☐ ☐ ☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐ ☐ ☐
Physician Name:	Phone: <i>Include area code</i>	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 diet 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?			☐	☐	☐
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 either of the medications, alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?			☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			☐	☐	☐
Date Treatment began:					
Allergies - Are you allergic to or have you had a reaction to: Yes No DK			Yes No DK		
To all yes responses, specify type of reaction.					
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			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			☐	☐	☐
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>					
Yes No DK			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			☐	☐	☐
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			☐	☐	☐
Glaucoma			☐	☐	☐
Hepatitis, jaundice or liver disease			☐	☐	☐
Epilepsy			☐	☐	☐
Fainting spells or seizures			☐	☐	☐
Neurological disorders			☐	☐	☐
If yes, specify:					
Sleep disorder			☐	☐	☐
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:		
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:

FOR COMPLETION BY DENTIST

Comments: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

I would like to allow the following people access to my medical information:

X _____ X _____

X _____ X _____

Patient Name: X _____

Relationship to Patient: X _____

Signature: X _____

Date: X _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Financial Policy and Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patient's financial capabilities.

Payment

Payment in full is due at the time of service unless financial arrangements are made prior to the date of your appointment. Unpaid accounts over 90 days will be turned over to a Collection Agency of our choosing. Payment options include:

Cash, Checks, VISA, MasterCard, AMEX and Discover

No interest monthly payment plans through CareCredit

Initial_____

Down Payment

You may be asked to pay a portion of your visit as a deposit upon scheduling treatment. Initial_____

Insurance

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can **estimate** your coverage in good faith, but **cannot guarantee it**. As a service to our patients, we will be happy to manage all dental claim submissions for up to two dental insurance policies and follow up on your behalf. If you have any questions, our courteous staff is always available to answer them. Please be aware some and possibly all of the services provided may NOT be covered by your insurance provider. Services, which are not covered, downgraded, or are considered not medically necessary by your insurance company are your responsibility. Initial_____

Minors

Payment for services for the treatment of minors can be made by check, cash, or credit card and is the responsibility of the adult accompanying that minor at the time of service. Initial_____

Missed Appointments

Once an appointment has been made, that time is reserved specifically for you. Patients who do not show up for an appointment or cancel with **less than 48 business hours notice are subject to a \$100 late cancel fee**. You may be asked to make a deposit before being reappointed. Initial_____

Service Charges

The policy of this office is to charge 2% interest monthly (24% annual percentage rate) to all accounts over 90 days past due. There will also be a \$25 fee for all returned checks. Initial_____

Financial Consent

The patient (account holder) agrees to be fully responsible for TOTAL payment of treatment performed in this office. Initial_____

I understand and agree to this Financial Policy and Agreement

X_____

Signature of Patient/Responsible Party

X_____

Date

Important Dental Insurance Information

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. There are differences in coverage and benefits among plans. We do our best to **estimate** coverage for you, but ultimately the contract is between you and your insurance company.

Our office is contracted as a preferred provider with most commercial insurance companies. Please inquire with your insurance company or one of our front office team members regarding our status with your insurance company. We encourage you to become familiar with your policy exclusions, deductibles and required co-insurance payments.

Our courtesy service to you includes:

- Filing your insurance claim for up to two policies within 48 hours of your visit and requesting payment of your insurance benefits to our office.
- Electronically filing your insurance for short turnaround, when possible
- Estimating covered services and benefits
- Following the American Dental Association guidelines for coding procedures and insurance billing.

Our expectations of you as the owner of the policy:

- Payments of fees not covered by your insurance company are to be paid at the time the services are rendered. Initial _____
- To understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier. Initial _____
- To recognize that dental insurance policies restrict payment for some services, and exclude some procedures based on prior conditions or length of time on the plan, or many other reasons listed in your benefit booklet. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment. Initial _____
- To take responsibility for payment if the insurance company does not pay our office within **90 days**. Initial _____
- If you have dual coverage, please call both companies to have then coordinate benefits and check to see if your insurance has a **non-duplication of benefits clause**. If it does, please become familiar with the restrictions. You may receive a **reduced benefit** from your secondary insurance. Initial _____
- To keep our office informed of any changes in your insurance coverage or employment. Initial _____
- To be aware some and possibly all of the services provided may NOT be covered by your insurance provider. Services, which are not covered, downgraded, or are considered not medically necessary by your insurance company are your responsibility. Initial _____

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

*I hereby authorize Oregon Smile Care Center to release to my insurance company any information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Oregon Smile Care Center. I understand that estimates given to me by Oregon Smile Care Center regarding my insurance are **not a guarantee of payment**. I am responsible for any unpaid balance after my insurance pays.*

X

Signature of Patient/Guardian

X

Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or restore to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fee of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in the arbitration of any person or entity that would otherwise be a proper addition party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal laws, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as the date of first professional services.

If any provision of the Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of the Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by a neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of the contract.

Patient Signature: x _____

Date: x _____