

MEDICAL HISTORY

Patient Name _____ Preferred Name _____ Age _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING: .. YES NO YES NO

- | | |
|--|--|
| <p>1. hospitalization for illness or injury <input type="checkbox"/> NO <input type="checkbox"/></p> <p>2. ALLERGIC REACTION TO</p> <ul style="list-style-type: none"> <input type="checkbox"/> aspirin, ibuprofen, acetaminophen <input type="checkbox"/> penicillin <input type="checkbox"/> erythromycin <input type="checkbox"/> tetracycline <input type="checkbox"/> codeine <input type="checkbox"/> local anesthetic <input type="checkbox"/> fluoride <input type="checkbox"/> metals (gold, stainless steel) <input type="checkbox"/> latex <input type="checkbox"/> any other medications <p>3. heart problems <input type="checkbox"/> NO <input type="checkbox"/></p> <p>4. heart murmur <input type="checkbox"/> NO <input type="checkbox"/></p> <p>5. rheumatic fever <input type="checkbox"/> NO <input type="checkbox"/></p> <p>6. scarlet fever..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>7. high blood pressure..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>8. low blood pressure <input type="checkbox"/> NO <input type="checkbox"/></p> <p>9. a stroke..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>10. artificial prosthesis (i.e. heart valve or joints).. <input type="checkbox"/> NO <input type="checkbox"/></p> <p>11. anemia or other blood disorder <input type="checkbox"/> NO <input type="checkbox"/></p> <p>12. prolonged bleeding due to a slight cut <input type="checkbox"/> NO <input type="checkbox"/></p> <p>13. emphysema <input type="checkbox"/> NO <input type="checkbox"/></p> <p>14. tuberculosis <input type="checkbox"/> NO <input type="checkbox"/></p> <p>15. asthma <input type="checkbox"/> NO <input type="checkbox"/></p> <p>16. sinus problems <input type="checkbox"/> NO <input type="checkbox"/></p> <p>17. kidney disease <input type="checkbox"/> NO <input type="checkbox"/></p> <p>18. liver disease <input type="checkbox"/> NO <input type="checkbox"/></p> <p>19. jaundice..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>20. thyroid or parathyroid disease..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>21. hormone deficiency..... <input type="checkbox"/> NO <input type="checkbox"/></p> | <p>22. high cholesterol <input type="checkbox"/> NO <input type="checkbox"/></p> <p>23. diabetes <input type="checkbox"/> NO <input type="checkbox"/></p> <p>24. stomach or duodenal ulcer..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>25. digestive disorders/regurgitation <input type="checkbox"/> NO <input type="checkbox"/></p> <p>26. arthritis..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>27. glaucoma <input type="checkbox"/> NO <input type="checkbox"/></p> <p>28. contact lenses..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>29. head or neck injuries..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>30. epilepsy, convulsions (seizures) <input type="checkbox"/> NO <input type="checkbox"/></p> <p>31. viral infections and cold sores <input type="checkbox"/> NO <input type="checkbox"/></p> <p>32. any lumps or swelling in the mouth..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>33. hives, skin rash, hay fever <input type="checkbox"/> NO <input type="checkbox"/></p> <p>34. sexually transmitted disease <input type="checkbox"/> NO <input type="checkbox"/></p> <p>35. hepatitis (type __)..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>36. HIV/ AIDS <input type="checkbox"/> NO <input type="checkbox"/></p> <p>37. tumor, abnormal growth, cancer..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>38. radiation therapy..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>39. chemotherapy <input type="checkbox"/> NO <input type="checkbox"/></p> <p>40. psychiatric treatment <input type="checkbox"/> NO <input type="checkbox"/></p> <p>41. alcohol/drug dependency..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>42. osteoporosis/low bone density..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>DO YOU:</p> <p>43. smoke <input type="checkbox"/> NO <input type="checkbox"/></p> <p>ARE YOU:</p> <p>44. presently being treated for any illness <input type="checkbox"/> NO <input type="checkbox"/></p> <p>45. aware of a change in your general health <input type="checkbox"/> NO <input type="checkbox"/></p> <p>46. often exhausted or fatigued..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>47. subject to frequent headaches <input type="checkbox"/> NO <input type="checkbox"/></p> <p>48. FEMALE – taking birth control pills..... <input type="checkbox"/> NO <input type="checkbox"/></p> <p>49. FEMALE – pregnant <input type="checkbox"/> NO <input type="checkbox"/></p> <p>50. MALE – Prostate disorders <input type="checkbox"/> NO <input type="checkbox"/></p> |
|--|--|

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment____

List any medications, herbal supplements, and or vitamins taken within the last two years, or bring a list for us to copy _____

Patient's Signature _____ Date: _____

DENTAL HISTORY

Referred by _____

Previous dentist _____

How long _____

Most recent dental exam _____

Most recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 months _____ 4 months _____ 6 months _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. unhappy with the appearance of your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
2. unfavorable dental experiences.....	<input type="checkbox"/>	<input type="checkbox"/>
3. dental fears.....	<input type="checkbox"/>	<input type="checkbox"/>
4. problems with effectiveness or bad reactions to dental anesthetic.....	<input type="checkbox"/>	<input type="checkbox"/>
5. orthodontic treatment (braces) when.....	<input type="checkbox"/>	<input type="checkbox"/>
6. periodontal (gum) treatment when.....	<input type="checkbox"/>	<input type="checkbox"/>
7. bleeding gums.....	<input type="checkbox"/>	<input type="checkbox"/>
8. avoid brushing any part of your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>
9. part of your mouth is sensitive to temperature.....	<input type="checkbox"/>	<input type="checkbox"/>
10. sore teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
11. a burning sensation in your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>
12. difficulty swallowing.....	<input type="checkbox"/>	<input type="checkbox"/>
13. an unpleasant taste or odor in your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>
14. dry mouth, throat, and or eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
15. jaw problems (temporomandibular joint).....	<input type="checkbox"/>	<input type="checkbox"/>
16. difficulty opening your mouth widely.....	<input type="checkbox"/>	<input type="checkbox"/>
17. stiff neck muscles.....	<input type="checkbox"/>	<input type="checkbox"/>
18. awaken with an awareness of your teeth or jaws.....	<input type="checkbox"/>	<input type="checkbox"/>
19. tension headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
20. clench or grind your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
21. jaw clicking or popping.....	<input type="checkbox"/>	<input type="checkbox"/>
22. lost any teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
23. do you sweat or tremble a lot during examination.....	<input type="checkbox"/>	<input type="checkbox"/>
24. do strange people or places make you afraid.....	<input type="checkbox"/>	<input type="checkbox"/>

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check yes or no)
<input type="checkbox"/>	<input type="checkbox"/>	Has your present denture been relined? When _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your present denture a problem? Describe _____
<input type="checkbox"/>	<input type="checkbox"/>	Satisfied with the appearance? _____
<input type="checkbox"/>	<input type="checkbox"/>	Satisfied with the comfort? _____
<input type="checkbox"/>	<input type="checkbox"/>	Satisfied with the chewing ability? _____
When did you receive your first partial or complete denture? _____		
How long have you worn your present denture? _____		

CONSENT

The undersigned hereby authorizes Dr. Madden or his legally designated auxiliary to take radiographs, or perform any other diagnostic tests which are deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. Madden or his legally designated auxiliary to perform any and all forms of treatment, medication and therapy that may be indicated for me. I also understand that dental treatment embodies certain risks with the use of anesthetics, drugs, medications or other procedures. These risks include, but may not be limited to: allergic reactions; nerve damage to the teeth or surrounding tissue resulting in temporary or permanent numbness or tingling of the tongue, lips and cheek; infection of the sinus or other surrounding areas; postoperative discomfort, bleeding, swelling and bruises, stiff jaws and potentially loosening of restorations. I realize that this dental treatment is elective and I understand there may be problems associated with delay and neglect. To the best of my knowledge, the information listed above is true and correct. I understand that it is my responsibility to pay for dental service provided to me or my dependents in this office, and that payment is expected in accordance with the written financial arrangements respective of dental insurance.

Patient's Signature _____ Date: _____

Doctor's Remarks: _____

Doctor's Signature/Date

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENTS NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	E-MAIL	
PATIENTS ADDRESS		STREET		APT#	CITY	STATE ZIP	
HOME PHONE		CELL PHONE		WORK PHONE		BEST NUMBER TO REACH YOU AT:	
MARITAL STATUS M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>		PATIENT'S EMPLOYER			OCCUPATION		
WORK ADDRESS		STREET		CITY	STATE	ZIP	
SPOUSE NAME		LAST		FIRST		MIDDLE	
				SPOUSE EMPLOYER		OCCUPATION	
WORK ADDRESS		STREET		CITY	STATE	ZIP	
						WORK PHONE	
EMERGENCY PERSON WE CAN CONTACT (OTHER THAN YOUR FAMILY HOME)							
NAME			WORK OR CELL PHONE		HOME PHONE		
NAMES OF OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?			

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE YES <input type="checkbox"/> NO <input type="checkbox"/>	INSURANCE COMPANY NAME		INSURANCE ADDRESS			
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/>		SUBSCRIBER'S DATE OF BIRTH		SSN
GROUP PROGRAM NUMBER	EMPLOYER - IF DIFFERENT FROM ABOVE			EMPLOYER'S ADDRESS		
INSURANCE COVERAGE YES <input type="checkbox"/> NO <input type="checkbox"/>	INSURANCE COMPANY NAME		INSURANCE ADDRESS			
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/>		SUBSCRIBER'S DATE OF BIRTH		SSN
GROUP PROGRAM NUMBER	EMPLOYER - IF DIFFERENT FROM ABOVE			EMPLOYER'S ADDRESS		

RELEASE

I authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

In consideration of the service rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I certify that I have read or had read to me the contents of this form and that the above information is correct.

Signature: _____ Date: _____ DSMD Publishing

CREDIT TERMS AND POLICY

We are pleased to offer a variety of financial options from which you may choose.

You may pay by:

- Cash
- Personal Checks
- Major Credit Cards
- Care Credit Payment Option

Payment in full is due at the time of service unless other arrangements have been made in advance.

The following payment options are also available to you:

- A. A 5% courtesy on balance that are paid in full by cash or check prior to or at the time of the first treatment appointment.
- B. In some cases, it may be possible to pay for treatment with 50% due on the day of initial treatment and the balance paid in one or two subsequent payments. Our Patient Care Coordinator will discuss these payment options with you. Balances outstanding more than 60 days from completion of treatment will incur a finance charge of 1% of the balance per month (12% APR).
- C. For patients who wish to pay for treatment over an extended period of time, we offer a payment plan that is administered by an independent company (Care Credit). The Treatment Coordinator will provide you with all the details.
- D. Insurance payments are accepted and we will do everything possible to help you maximize your benefits. Patients are responsible for the difference between the actual insurance payment and the fee. Please contact your insurance company for more information.

I have read or had read to me the above credit terms and policy and agree to pay in accordance with these terms.

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Linda Madden, Patient Care Coordinator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date/Time

Printed Name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This form will be retained in your medical record.

Last Update: April 14, 2003

You may share my Protected Health Information with _____.

Dated: _____ Signed: _____