

DELLMEN HECHT, D.D.S., P.C.
PERIODONTICS & IMPLANTS

PATIENT HEALTH HISTORY

NAME _____ SOCIAL SECURITY # _____ BIRTH DATE _____
HOME PHONE _____ E-MAIL ADDRESS _____
ADDRESS _____ ZIP _____
EMPLOYER _____ WORK PHONE _____ FAX # _____
ADDRESS _____ INSURANCE _____
DENTIST _____ # _____ PHYSICIAN _____ # _____
REFERRED BY _____ REASON _____
EMERG. CONTACT _____ RELATIONSHIP _____ PHONE _____

PLEASE MARK YES ANSWERS WITH A CHECK MARK (✓). UNDERLINE WHERE NECESSARY.

_____ Have you ever been treated for any heart condition, high blood pressure, or any chronic illness such as asthma, kidney disease, HIV, etc.? (please underline)

_____ Have you had prolonged bleeding from any injury, tooth extraction, etc.?

_____ Have you had any illness or condition other than the common cold or flu? If so, what?

_____ Have you ever had rheumatic fever or mitral valve prolapse?

_____ Are you allergic to any medicine or drug, i.e. Penicillin, Codeine, Novocain or Latex?

_____ Have you recently had any evidence of infection, such as persistent sore throat or cough?

_____ Do you use any medications or drugs regularly, including birth control pills, vitamins, aspirin, or other supplements? Please list:

_____ Are you having any pain today?

_____ Do you have pain from chewing?

_____ Have you had any spaces open between teeth?

_____ Do you smoke? How much? _____

_____ Do your gums bleed or hurt when you brush?

_____ Do you often experience bad breath, bad taste?

_____ Do you grind or clench your teeth in your sleep?

_____ Do you get toothaches from hot, cold, or sweet?

_____ Are you aware of the relationship between gum disease and strokes/ heart attacks?

_____ Is there anything about the appearance of your teeth or smile that you would like to change?

_____ Have your gums ever been treated?

_____ Do you often have dry mouth?

_____ Does your bite feel high?

_____ Are you aware of any loose teeth?

_____ Are you pregnant or nursing?

_____ Do you use nitrous oxide?

_____ Does your jaw ever click or feel tired?

_____ Are you in good health?

Please list the oral hygiene aids that you use every day: _____

IT IS OUR WISH THAT YOU BE AS COMFORTABLE AS POSSIBLE DURING YOUR VISIT TO OUR OFFICE. HOW DO YOU RATE YOUR LEVEL OF DENTAL ANXIETY ON A 1-10 SCALE, 10 BEING THE HIGHEST. _____

IF THERE IS ANY PHASE OF YOUR DENTAL TREATMENT THAT PARTICULARLY CONCERNS YOU, PLEASE SPECIFY IN DETAIL. _____

SIGNATURE _____ DATE _____

DENTAL QUESTIONNAIRE FOR _____

YOUR DENTIST'S NAME _____ FOR HOW LONG: _____

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS:

☐ LESS THAN ONCE A YEAR ☐ ONCE A YEAR ☐ TWICE A YEAR ☐ THREE TIMES A YEAR ☐ FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM _____ MO/YEAR OF YOUR LAST DENTAL X-RAYS _____

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH(CIRCLE ONE):

☐ VERY SATISFIED ☐ SATISFIED ☐ IT'S O.K. ☐ SOMEWHAT DISSATISFIED ☐ VERY DISSATISFIED

YES NO

☐ ☐ DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?

IF YES, PLEASE DESCRIBE? _____

☐ ☐ ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?

IF YES, PLEASE DESCRIBE: _____

☐ ☐ ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS FOR INFECTION? IF SO, WHAT: _____

☐ ☐ DO YOUR GUMS EVER BLEED? IF SO, WHEN: _____

☐ ☐ DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?

☐ ☐ ARE YOU INTERESTED IN REPLACING LOST TEETH?

☐ ☐ DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?

☐ ☐ ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?

☐ ☐ ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?

☐ ☐ ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL? WHEN? _____

☐ ☐ ARE YOU CONCERNED ABOUT GUM RECESSON AROUND ANY OF YOUR TEETH?

☐ ☐ ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?

☐ ☐ HAVE YOU EVER HAD ORTHODONTIC TREATMENT? ☐ WITH BRACES ☐ WITH REMOVABLE APPLIANCES

WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____

☐ ☐ HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT? ☐ SCALING/ROOT PLANING ☐ GUM SURGERY

WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR MAKES DENTAL TREATMENT EASIER FOR YOU:

- ☐ I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA
- ☐ I APPRECIATE THE USE OF LOCAL ANESTHETIC - IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL
- ☐ I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL
- ☐ I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)
- ☐ I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT
- ☐ I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE
- ☐ I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR
- ☐ I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM
- ☐ I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY, _____)

WHAT ARE YOUR GOALS OR PRIORITIES FOR THE HEALTH, FUNCTION AND APPEARANCE OF YOUR TEETH & MOUTH:

(RATE EACH ITEM FROM 1 TO 5 WITH 1 BEING YOUR LOWEST PRIORITY AND 5 YOUR HIGHEST - YOU CAN USE ANY NUMBER MORE THAN ONCE)

____ BE ABLE TO CHEW FOOD AND EAT WHAT I ENJOY

____ AVOID REMOVABLE BRIDGEWORK

____ PRESERVE MY TEETH & AVOID DENTURES

____ FOR MY MOUTH TO LOOK NICE WHEN I SMILE

____ BE FREE OF INFECTION

____ MAKE MY TEETH LOOK GOOD

____ BE FREE OF MOUTH PAIN & TENDERNESS

____ HAVE A HEALTHY AND HASSLE-FREE MOUTH

Signature of patient or legal guardian

Date

Reviewed by

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr. _____
Last First Middle Initial
I wish to be called at: home work other _____ Name of Spouse/Partner _____
Address _____ Apt. No. _____
City, State, Zip _____
Home Phone (____) _____ Work Phone (____) _____ Ext.# _____
Email Address _____
Birthdate _____ Social Security # _____ - _____ - _____
Referred by _____ Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of insured _____
Relationship to Patient _____
Insured's Birthdate _____
Soc. Sec. # _____ - _____ - _____
Employer _____
Insurance Co. _____
Insurance Address _____
City, State, Zip _____
Insurance Phone _____
Group # _____
Group Name _____

Secondary Insurance

Name of Insured _____
Relationship of Patient _____
Insured's Birthdate _____
Soc. Sec. # _____ - _____ - _____
Employer _____
Insurance Co. _____
Insurance Address _____
City, State, Zip _____
Insurance Phone _____
Group # _____
Group Name _____

____ I am not covered by any Dental Insurance at this time

I hereby authorize Provider, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Provider_1 of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Academy of Periodontology, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Provider_2.

Privacy of Information Policy: I have been informed that this practice will make reasonable efforts to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is canceled with less than 2 working days notice. All other appointments require 1 full working day's notice for any change. **Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.**

I acknowledge that I have read and understand the above statements and policies, and that this authorization remains valid and effective from the date of signing until revoked in writing.

Signature of Patient or Patient's Legal Guardian

Date of Signature

DELLMEN HECHT, D.D.S., P.C.
PERIODONTICS & IMPLANTS

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options:

- ☐ Payment by cash.
- ☐ Payment by check.
- ☐ Payment by credit card.
- ☐ Automatic monthly billing to your Visa or Master Card.
- ☐ Dental Fee Plan (For charges of \$300 or more)

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa or Master Card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or Master Card on a monthly basis.

If none of the above applies, please see the office manager. Thank you.

All charges are due at the time of service. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.

**** Please Be Advised That There Is A Fee All Broken Appointments!! ****

Print your name here and sign below

Date _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Dellmen Hecht, DDS to furnish information to insurance carriers concerning my treatments and I do hereby assign to him all payments for dental services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

Print your name here and sign below

Date _____

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