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?

_____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?

_____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?
____

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 ANTIBIOITICS 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 RECESSION 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
____PRESERVE MY TEETH & AVOID DENTURES
____BE FREE OF INFECTION
____BE FREE OF MOUTH PAIN & TENDERNESS
____AVOID REMOVABLE BRIDGEWORK
____FOR MY MOUTH TO LOOK NICE WHEN I SMILE
____MAKE MY TEETH LOOK GOOD
____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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