Dental and Medical History
Howard S. Snider, DMD & Gretchen K. Henson, DDS

Patient Name *(please print)*_____ ***Date***_____

Dental History
*Date of last dental visit:*_____ *Previous Dentist:*_____ *How long?*_____

How <u>often</u> do you/did you have your teeth cleaned? ☐ *every 3 months* ☐ *every 6 months* ☐ *every 12 months* ☐ *other*

What is your immediate dental concern?_____

If you have or previously had any of the following dental concerns, please check the box:

Bad breath/taste in mouth ☐	Fingernail biting ☐	Mouth breathing ☐
Bleeding gums ☐	Food collecting between teeth ☐	Orthodontic treatment (braces) ☐
Blisters on gums or lips ☐	Grinding or clenching your teeth ☐	Pain around ear ☐
Burning sensation on tongue ☐	Swollen or tender gums ☐	Periodontal (gum) treatment ☐
Chew on one side of mouth ☐	Jaw Pain / TMJ ☐	Sensitive to cold ☐
Clicking or popping jaw ☐	Lip or cheek biting ☐	Sensitive to heat ☐
Dry mouth ☐	Loose or broken fillings ☐	Sensitive to sweets ☐
Bad dental experiences ☐	Sores or growths in mouth ☐	Sensitive to biting ☐

Physician's Name:_____ ***Phone:***_____

Emergency Contact_____ ***Phone***_____

If you have had any of the following, please check the box: *(* You may require antibiotic pre-medication prior to dental treatment for this condition.)*

Anemia ☐	Diabetes Type I * ☐ / Diabetes Type II ☐	Kidney / Renal Disease ☐
Arthritis / Rheumatism ☐	Emphysema / Tuberculosis ☐	Liver Disease ☐
Asthma / Lung Disease ☐	Epilepsy / Seizures ☐	Osteoporosis/ Fosamax * ☐
Back Problems ☐	Fainting / Dizziness ☐	Pacemaker ☐
Blood Pressure: Low ☐ / High ☐	Glaucoma ☐	Psychiatric Care / Alzheimer's ☐
Bleeding disorder / Bruise easily ☐	Headaches / Migraines ☐	Rheumatic Fever * ☐
Blood Disease / Hemophilia / Leukemia ☐	Hepatitis B ☐ or C ☐	Seasonal Allergies / Hay Fever ☐
Circulatory Problems / Anticoagulants ☐	Heart Trouble / Heart Disease ☐	Sinus problems / Sinus surgery ☐
Blood Transfusion ☐	Irregular heart beat ☐	Stomach / Intestinal Disorders ☐
Cancer / Tumors / Growths ☐	Heart attack / Chest Pain / Angina * ☐	Stroke ☐
High Cholesterol ☐	Heart Murmur * ☐	Tattoos ☐
Chemotherapy / Radiation Treatment ☐	Artificial heart valves * ☐	Thyroid: Low ☐ / High ☐
Chemical Dependency / Substance Abuse ☐	Mitral Valve Prolapse * ☐	Fen-Phen / weight loss medication * ☐
Cough (chronic) ☐	HIV / AIDS ☐	Other_____

List any surgeries/hospitalizations over the past 5 years _____

_____

Do you smoke or chew tobacco? Y ☐ / N ☐ *Amount per day*_____
Do you have any artificial joints or any pins in your body?*_____
Have you had a prior joint space infection?*_____
Do you have any ***allergies*** *to medications, latex or acrylic?* _____

Women*: Are you pregnant?* Y ☐ / N ☐ *Are you trying to get pregnant?* Y ☐ / N ☐ *Are you nursing?* Y ☐ / N ☐

Please list all medications (prescription and over the counter) including herbal remedies and vitamins: _____

_____

Privacy Policy ☐ *Ok to disclose your health information to a physician or specialist providing treatment to you.*
☐ *Ok to leave messages regarding dental appointments/ treatment: email:* _____

I hereby authorize payment directly to this dental office and understand that my dental insurance is an agreement between my insurance company and me. I understand I am ultimately responsible for all charges incurred at this office regardless of insurance benefits.

Patient Signature_____

Doctor's Signature_____ ***Date Reviewed***_____

ADVANCED DENTAL HEALTH, PC

Howard S. Snider DMD
Gretchen K. Henson, DDS
5110 E Warner Road, Suite #250
Phoenix, AZ 85044
Phone 480-783-7192 Fax 480-783-7193

Our Mission

In our dental practice, we strive to serve the needs of you, our valued patients, to the best of our ability. We aim to provide the highest quality dental care in a relaxed and comfortable environment. We understand that you have a choice in dental care, and we thank you for choosing our office.

Patient Agreements

Confirmation

_____ *It is imperative that you confirm your scheduled appointment with our office at least 2 business days prior to your appointment. Your appointment time is reserved for you. We do not double book our providers. Confirming your appointment allows us to provide quality care and appointment times for all of our patients. You may reach us during office hours, leave a voice mail message after hours, or send an email to adh.office@adhaz.com. If we have not heard from you, we will make every effort to contact you at the numbers you have provided us. Unconfirmed appointments are subject to cancellation.*

Arrival

_____ *We understand that your time is limited and valuable. We will make every effort to see you at your appointed time. For this reason, we ask you to be ready for treatment at your appointed time. We understand that unforeseen circumstances can cause delays in your arrival. In order to provide you with the necessary time to complete your treatment, we may ask that you reschedule any appointment that we cannot complete during your scheduled time.*

Minors

_____ *Children under the age of 18 must be accompanied by a parent or legal guardian for the first dental visit in our office. Future dental treatment will not be performed without prior arrangements between our office and a consenting adult. If a minor child arrives unattended for dental treatment, the appointment will be rescheduled.*

Length of Appointment

_____ *In order to serve you with our undivided attention, we schedule your dental treatment as a block of time. This allows us to focus only on you and assures you that you will be finished with your dental appointment on time. For any appointment longer than 60 minutes, we ask for one-half of your payment when the appointment is made and the second half at your scheduled appointment.*

Cancellations and Rescheduling

_____ *We understand that it may become necessary to change an appointment. As a courtesy to our staff and to our other patients, we ask that you let us know immediately if you cannot keep your appointment. Appointments cancelled or rescheduled fewer than 2 business days in advance may be assessed a $75.00 cancellation fee.*

Dental Insurance

_____ *As a professional courtesy, we will submit your dental insurance claims. While we will assist you in obtaining benefit information, we are not privileged with the detailed provisions of your particular plan. All estimates provided in our office are based on general benefit information. Questions regarding your specific dental benefits should be directed to your insurance company. You are ultimately responsible for all charges incurred in our office. You will receive a statement from our office for any unpaid balances.*

_____ _____

Patient Name / Parent or Legal Guardian *Date*

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CONSENT TO DISCLOSE HEALTH CARE INFORMATION

I, _____ (patient), hereby give my consent for the following individuals to act on my behalf in scheduling my treatment, discussing my treatment and handling my finances concerning my dental care at Advanced Dental Health, PC, the office of Howard Snider D.M.D. and Gretchen Henson D.D.S.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I will notify this office if I want to add or remove these individuals from this list.

_____ _____
Patient Date