

PETER M. HECKLER, D.D.S., INC.
NANCY MORROW, D.D.S.

FAMILY & COSMETIC DENTISTRY

PERSONAL INFORMATION

Today's Date _____
Name _____
What do you wish to be called _____
Referred by _____
Email address _____
Address _____
City/State/Zip _____
Home Phone _____ Business/Cell _____
Where do you prefer to receive calls _____
 Male Female Single Married
Date of Birth _____
SS # _____
Occupation _____
Emergency Contact _____ Relationship _____
Home Phone _____ Cell Phone _____
If you are completing this form for another person what is your relationship to that person _____

RESPONSIBLE PARTY

Who is responsible for the account?
Name _____
Birth date _____ SS# _____
Relationship to patient _____
Address _____
City/State/Zip _____
Employer _____
Employer Address _____
Work Phone _____ Home Phone _____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

Cash Personal Check Credit Card Visa MC

Late charges: If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION & RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

X _____
Signature of patient or parent if minor Date

DENTAL INSURANCE INFORMATION

Name of Insured _____
Relationship to patient _____
Insured's birth date _____ SS# _____
Employer _____ Date Employed _____
Employer Address _____
Insurance Company _____
Group # _____
Ins. Co. Address _____

ADDITIONAL INSURANCE

Name of Insured _____
Relationship to patient _____
Insured's birth date _____ SS# _____
Employer _____
Employer Address _____
Insurance Company _____
Group # _____
Ins. Co. Address _____

DENTAL HISTORY

Yes No

Yes No

- Do your gums bleed when you brush or floss?
Are your teeth sensitive to cold, hot, sweets or pressure?
Does food or floss catch between your teeth?
Is your mouth dry?
Have you had any periodontal (gum) treatments?
Have you ever had orthodontic (braces) treatment?
Have you had any problems associated with previous dental treatment?
Is your home water supply fluoridated?
Do you drink bottled or filtered water?
If yes, how often, choose one: DAILY, WEEKLY, OCASSIONALLY
Do you have earaches or neck pains?

- Do you have any clicking, popping or discomfort in the jaw?
Do you brux or grind your teeth?
Do you have sores or ulcers in your mouth?
Do you wear dentures or partials?
Do you participate in active recreational activities?
Have you ever had a serious injury to your head or mouth?
Date of your last dental exam?
Name of previous dentist?
What was done at that time?
Date of last x-rays?
What is the reason for your dental visit today?

MEDICAL HISTORY

Are you under a physician's care now? Name City

Have you ever been hospitalized or had a major operation? Discuss

Have you ever had a serious injury to your head or neck? Discuss

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger)?

Date: If yes, have you had any complications?

Do you use controlled substances (drugs)?

Are you allergic to any medications or substances? Please check applicable:

- Aspirin Pencilin Codeine Acrylic Metal Latex Rubber Dental Anesthetic Iodine
Other

Women (Please check) Pregnant/Trying to get pregnant Breast Feeding Taking oral contraceptives

Table with 3 columns: Condition, Yes, No, DK. Rows include: 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, Cardiovascular disease, Angina, Arteriosclerosis, Congestive Heart Disease, 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, Hemophilia, AIDS or HIV infection, Arthritis, Autoimmune disease, Rheumatoid arthritis, Systemic lupus erythematosus, Asthma, Bronchitis, Emphysema, Sinus trouble, Tuberculosis, Cancer/Chemo./Radiation Treatment, Chest pain / palpitation, 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, Recurrent infections, Type of infections, Kidney problems, Night sweats, Osteoporosis, Persistent swollen nodes in neck, Severe headache, Frequent rapid heart rate, Sexually transmitted disease, Excessive urination.

Yes No Are you taking any medications, pills or drugs? What?

Yes No Have you ever had any other serious illness not checked above? Discuss

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff on the next appointment without fail.

X PATIENT SIGNATURE (PARENT OR GUARDIAN) Date

Reviewed by Doctor Date BP

History Review and Significant Findings