

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?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam? _____		
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	Name of previous dentist? _____		
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____		
If yes, how often, choose one: DAILY, WEEKLY, OCASSIONALLY			Date of last x-rays? _____		
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	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

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux persistent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes date _____				Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except to the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD</i>				Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____			
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infections _____			
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kldney problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemo./Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain / palpitation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen nodes in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent rapid heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Gastrointestinal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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 _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____

History Review and Significant Findings _____